Maternal and Child Health Services
Title V Block Grant

State Narrative for Virginia

Application for 2015
Annual Report for 2013

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I. General Requirements

A. Letter of Transmittal

The Letter of Transmittal is to be provided as an attachment to this section.

B. Face Sheet

The Face Sheet (Form SF424) is submitted when it is submitted electronically in HRSA EHB. No hard copy is sent.

C. Assurances and Certifications

Copies of signed assurances and certifications for Virginia are maintained on file in the Office of Family Health Services, Virginia Department of Health. Copies are available by contacting the Title V Director, Office of Family Health Services, 109 Governor Street, 7th Floor, Richmond, VA 23219 or by phone at (804) 864-7650.

D. Table of Contents

This report follows the outline of the Table of Contents provided in the "GUIDANCE AND FORMS FOR THE TITLE V APPLICATION/ANNUAL REPORT," OMB NO: 0915-0172; published January 2012; expires January 31, 2015.

E. Public Input

In Virginia, opportunity for public input into the MCH planning process is ongoing, utilizing the variety of stakeholders and linkages described elsewhere in the application. In FY 2010 Virginia focused specific efforts on obtaining public input for the five-year needs assessment and the FY 2011 Title V application. These efforts included a PowerPoint presentation describing Title V and the MCH services that Virginia provides that was developed and placed on the OFHS website (www.vahealth.org), a survey of district health departments, key stakeholder interviews, and focus groups. Marjory Ruderman from Johns Hopkins University facilitated a priority-setting meeting that included input from external partners as well as the OFHS staff.

During the current year routine mechanisms continued in place to obtain input and feedback on specific MCH programs. The Office of Family Health Services utilizes advisory groups and task forces that regularly provide input into specific MCH programs. Public notification and the draft MCH Block Grant application were made available on the OFHS website along with the 2011 Needs Assessment. In addition, emails were sent to numerous stakeholders notifying them of the availability of the draft application. These stakeholders included the following:

Health District Directors, Nurse Managers, and Business Managers of Virginia's 35 local health districts
Children with Special Healthcare Needs (CSHCN) Families
Care Connection for Children
Early Hearing Detection and Intervention Advisory Board
Family to Family Network of Virginia
Genetics Advisory Committee
Infant and Toddler Connection
Medical Home Plus
Virginia Association of Family Physicians
Virginia Association of Obstetricians and Gynecologists
Virginia Association of Women's Health, Obstetric, and Neonatal Nurses
Virginia Bleeding Disorders Program

Virginia Chapter of the AAP
Virginia Coordinated Chronic Disease Partners
Virginia Council of Nurse Practitioners
Virginia Dental Association
Virginia Department of Education
Virginia Department of Medical Assistance Services
Virginia Early Childhood Foundation
Virginia Health Care Foundation
Virginia Home Visiting Consortium Members
Virginia Injury Network
Virginia Nurses Association
VA-Lend (VA Leadership Education in Neuro-developmental Disabilities Program)

VDH solicited public comment on the draft FY 2015 MCH Title V Block Grant State Narrative from stakeholders across the state. In an effort to increase participation in the public comment process, an Executive Summary of the Narrative, containing a link to the full Narrative, was prepared and sent to stakeholders via email. The Narrative and Executive Summary were also made available online through both the VDH main webpage and the Office of Family Health Services webpage. The comments received were reviewed by the OFHS leadership and incorporated as appropriate.

A detailed summary of the individual comments is attached to this section.

After transmittal to MCHB, the final application will be available on the OFHS website. The OFHS will continue to seek opportunities during FY 2015 to present information regarding Virginia's Title V funded programs at various meetings with interested parties and obtain on-going stakeholder input.

II. Needs Assessment

In application year 2015, Section IIC will be used to provide updates to the Needs Assessment if any updates occurred.

C. Needs Assessment Summary

Since the last needs assessment, the biggest factors impacting the needs of the maternal and child health population in Virginia are related to changing demographics. Data from the 2010 U.S. Census show population growth across all racial and ethnic groups in the state. The most notable increase is from the Hispanic population, which increased by 92% from 2000 to 2010. In addition, since the economic downturn began, an additional 33,000 children in Virginia are now considered to be living in poverty an increase from 12.2% in 2006 to 14.6% in 2010. These factors are indicators that more Virginians will need services and support from Title V and there will be a need for more linguistically and culturally competent programs.

New years of data continue to be released from multiple sources (such as Vital Records, PRAMS, BRFSS). For the first time ever, the Virginia Department of Health (VDH) partnered with the Virginia Foundation for Healthy Youth for a combined youth survey in 2013 that incorporated both the Virginia Youth Survey and the Virginia Youth Tobacco Survey. Also, for the first time these surveys were administered regionally in both middle and high schools. Once the CDC analyzes the results data on the five public health planning regions in Virginia will be made available on the VDH website.

The Virginia Behavioral Risk Factor Surveillance System (BRFSS) collected additional health data in 2013 concerning health insurance coverage in an effort to monitor the effects of the Affordable Care Act (ACA) in Virginia. This data is also currently being collected in 2014. The 2013 and 2014 health insurance data may be used as a baseline for ACA impact as ACA is projected to be fully implemented in subsequent years.

Currently, the Virginia BRFSS is also collecting additional health data by including optional modules on pre-diabetes, diabetes, T-DAP, social context, and sexual orientation and gender identity.

During the year, additional data updates and analysis continued to be routinely provided to the Health Commissioner's Infant Mortality Work Group. This group has been actively involved in examining the relevant data, sharing evidence-based programs used in other states and around the Commonwealth and setting priority goals and objectives. Having fullfilled its mission, the Work Group was disbanded following the development of the five-year Thriving Infants Strategic Plan. Teams have been established to implement the plan.

Based on a 2011 evaluation of Virginia's Pregnancy Risk Assessment Monitoring System (PRAMS), VDH made several minor changes and improvements to the project which, as a result, continues to function well with improvements in efficiency and work flow. Beginning in April 2012, Virginia PRAMS modified the program incentive to be more appealing to participants. In addition, Virginia PRAMS initiated a contract with the survey research center at the University of Virginia to conduct telephone interviews. It is expected that these changes will increase all phases of survey response rates.

PRAMS continues to provide high-quality data to inform maternal and child health programs and policy. In the past year PRAMS has provided data to the Women & Infants program, Dental Health program, and the Commissioner's Workgroup on Infant Mortality. Additionally, Virginia PRAMS data is routinely used by the Health Commissioner to track and demonstrate issues and disparities that exist during pregnancy and early infancy.

A Title X needs assessment was completed in the summer of 2012 in conjunction with the VDH application for competitive Title X funding in 2014-2017. Data collection and analysis contained in this assessment helped to identify the need for reproductive health services in Virginia and determine populations and geographic areas to target. A key finding from the needs assessment revealed that the Virginia Family Planning Program serves 19% of the unmet need for publicly funded comprehensive family planning.

An annual meeting of MCH program staff was held to review the National and State Title V Performance Measures, the Health Status Indicators and the Health Systems Capacity Indicators. The review was followed by a discussion of issues and potential responses.

III. State Overview

A. Overview

Geographic Description

The Commonwealth of Virginia is a mid-Atlantic state, bordered by Washington D.C., the nation's capitol, and Maryland to the north; the Atlantic Ocean to the east; and to the south North Carolina; and Tennessee, West Virginia and Kentucky to the west. Virginia encompasses 42,774 square miles (110,784 km2) making it the thirty-fifth largest state by area. The Virginia Department of Health has grouped its 134 localities (cities and counties) into 35 health districts and 5 health planning regions. The Northern Region, composed of Loudoun, Fairfax, Alexandria, Arlington and Prince William health districts located just south of Washington, D.C., is densely populated and includes six of the twenty highest income counties in the United States. However, with over 150 languages spoken in the region, and limited translation and interpretation services, communication can be problematic and interfere with access to health services. In addition, this region has severe daily traffic congestion. Conversely, the Southwest Region, made up of Lenowisco, Cumberland Plateau, Mount Rogers, West Piedmont, New River, Alleghany and Roanoke health districts, bordered by West Virginia, Kentucky and Tennessee, is rural with a rugged and mountainous terrain and is the least populous and least racial/ethnically diverse. Its terrain and vast geographic area pose many transportation barriers. Ice and snow during the winter months can hamper travel. The East Central Region is composed of Southside, Piedmont, Crater, Chesterfield, Richmond, Henrico, Chickahominy, Three Rivers and Rappahannock health districts. West Central Region is made up of Pittsylvania/Danville, Central Virginia, Thomas Jefferson, Central Shenandoah, Rappahannock/Rapidan and Lord Fairfax. These two regions have a mix of urban, suburban and rural areas. The urban areas are home to large state universities/ colleges and are business districts. The suburban areas are more residential than industrial. The rural areas are agricultural. The Eastern Region, composed of Western Tidewater, Chesapeake, Virginia Beach, Portsmouth, Norfolk, Hampton, Peninsula, and Eastern Shore health districts, runs along the east coast (Chesapeake Bay and Atlantic Ocean) and includes the Eastern Shore, a peninsula separated from the mainland by the Chesapeake Bay. The Eastern Shore Health District is very sparsely populated and has high poverty. The Eastern region has the largest concentration of military bases and facilities of any metropolitan area in the world. The coastal region has many bridges and tunnels that create transportation barriers to services. The region also has daily severe traffic congestion. Occasionally, hurricanes and tropical storms affect the area and can bring flooding. More information regarding local health districts can be found at www.vdh.virginia.gov/lhd.

Demographic Description

Virginia's population is growing and changing. It reached 7.77 million in 2008, maintaining the Commonwealth's position as the 12th largest state population in the country with an annual growth rate of about 1.12 percent since 2000. In 2007, among people reporting one race alone, 70 percent were non-Hispanic White, 20 percent were non-Hispanic Black, and 5 percent were Asian. Compared to the nation, Virginia had a slightly higher proportion of Black or African American population. The proportion of Hispanics in Virginia (6.5%) was significantly lower than the national average (15.1%). Most of the minority populations in Virginia reside in the three major metropolitan areas of the state. Within Virginia, two metropolitan areas are clearly much more densely populated and developed than other areas of the state: The Northern region has the largest number of housing units and people per square mile, followed closely by Hampton Roads. In 2008, the Northern region had a housing density of 324.3 per square mile, while Hampton Roads was at 285.0 homes. The Southside region had the sparsest housing density at only 28.8 houses per square mile. Housing density is closely correlated with population density data. In this, too, the Northern and Hampton Roads regions have the highest population density rates, while the Southside region has the lowest in the state. In 2000, 73 percent of Virginia's population lived in urban areas, lower than the national average of 79 percent. California had the highest percent (94%) of people living in urban areas. The urban population rates for North

Carolina, Tennessee and Maryland were 60 percent, 64 percent and 86 percent respectively. Not surprisingly, urban populations within Virginia are largest in Hampton Roads, with 92 percent, and the Northern Region, with 91 percent. The Southwest and Southside regions had the largest rural populations, at 75 percent and 65 percent respectively.

/2014/ Virginia's population is growing and changing. It reached nearly 8.2 million in 2012, maintaining the Commonwealth's position as the 12th largest state population in the country with an annual growth rate of about 1.12 percent since 2000. In 2012, among people reporting one race alone, 71 percent were non-Hispanic White, 20 percent were non-Hispanic Black, and 6 percent were Asian. Compared to the nation, Virginia had a slightly higher proportion of Black or African American population. The proportion of Hispanics in Virginia (8.4%) was significantly lower than the national average (16.9%). Seventy percent of Virginia's population reside in the three major metropolitan areas of the state. Within Virginia, two metropolitan areas are clearly much more densely populated and developed than other areas of the state: The Northern region has the largest number of housing units and people per square mile, followed closely by Hampton Roads. In 2008, the Northern region had a housing density of 324.3 per square mile, while Hampton Roads was at 285.0 homes. The Southside region had the sparsest housing density at only 28.8 houses per square mile. Housing density is closely correlated with population density data. In this, too, the Northern and Hampton Roads regions have the highest population density rates, while the Southside region has the lowest in the state. In 2010, 76 percent of Virginia's population lived in urban areas, lower than the national average of 81 percent. California had the highest percent (95%) of people living in urban areas. //2014//

Virginia's population has grown by more than 800,000 since the 2000 census -- a growth rate of 11.4 percent over nine years. The Commonwealth's 1.12 percent annual growth rate between 2000 and 2008 was 15th highest among states, and higher than the nation's rate of 94 percent. The 2009 provisional state population estimate is 7,882,590, which represents an increase of more than 87,000 since 2008. Virginia's metropolitan areas account for 93.5 percent of the population growth since 2000; as a result, by July 2009, more than 85.7 percent of Virginians lived in one of the state's metropolitan areas. Rural and small-town Virginia represents a diminishing share of the state's population. While some urban localities (such as Fairfax, Chesterfield and Chesapeake) have large increases in population, they may not register as among those with the fastest rate of growth, due to the size of their population.

/2014/ The commonwealth's growth rate (13 percent) outpaced the nation (9.7 percent) and was only slightly lower than the 14.4 percent growth rate of the prior decade. Virginia is the only state in which natural increase (more births than deaths) and net in-migration (in-migration less out-migration) contributed equal shares to population growth. The 2011 state population was 8,096,064, which represents an increase of 1.2 percent over the 2010 level. Virginia's metropolitan areas account for 82 percent of the population growth and 70 percent of the states population. Rural and small-town Virginia represents a diminishing share of the state's population. While some urban localities (such as Fairfax, Chesterfield and Chesapeake) have large increases in population, they may not register as among those with the fastest rate of growth, due to the size of their population. //2014//

According to the University of Virginia's Weldon Cooper Center for Public Service, three critical trends will shape Virginia's population over the next few decades: selective decentralization, an aging population, and increasing racial and ethnic diversity. As noted earlier, people are moving away from the state's central cities and counties to the surrounding suburbs and exurbs, thus increasing selective decentralization. As a result, the number of metropolitan areas is expected to increase, and the boundaries of existing metro areas are expected to expand. Rural counties adjacent to metro areas are likely to experience significant population growth as space and affordable housing become harder to obtain in the urban core areas. Counties with significant quality-of-life advantages, those with access to urban amenities (either their own or nearby), and those with a diversified, service-based economy are particularly prone to rapid growth. The state's 11 metropolitan areas contained about 86 percent of the total population in 2007 and

almost 69 percent of all Virginians lived in just three metropolitan areas: Northern Virginia, Richmond, and Virginia Beach. These three metropolitan areas accounted for more than 83 percent of state population growth from 2000 to 2007.

The population will continue to age. About 21.9 percent of all households in 2007 had one or more persons age 65 years and older and 39.4 percent of persons age 65 years and older had a disability. In Virginia today, older adults comprise 11 percent of people receiving Medicaid services yet drive nearly 25 percent of Virginia's total Medicaid spending and 50 percent of Medicaid spending on long-term care services. As the population grows and ages in the next 20 years, many more people will become dependent on Medicare and Medicaid for health insurance coverage.

/2014/ The population will continue to age. About 12.5 percent the population in was 65 years and older and 39.4 percent of persons age 65 years and older had a disability. In Virginia today, older adults comprise 11 percent of people receiving Medicaid services yet drive more than 20 percent of Virginia's total Medicaid spending and 50 percent of Medicaid spending on long-term care services. As the population grows and ages in the next 20 years, many more people will become dependent on Medicare and Medicaid for health insurance coverage. //2014//

/2015/ Virginia, like the nation as a whole, is becoming older and more diverse. Significantly, the largest absolute growth projected from 2010 to 2030 is in the 65 years and older age group, when the elderly are expected to comprise almost 19 percent of the total population. Another way to assess the relative impact of aging is through the age dependency ratio, which is the number of children (17 years old or younger) plus the number of elderly (65 and older) per 100 individuals ages 18 through 64. Viewed through this lens, Virginia compares relatively well with other states: In 2010, Virginia had the fourth lowest age dependency ratio in the nation at 54.7. Another measure is the so-called old age dependency ratio (the number of elderly per 100 individuals 18 to 64). Using this measure, Virginia was seventh lowest in the nation. These rates vary widely in Virginia and range from a low of 13.4 in Northern Virginia to 34.4 in the Eastern region and 29.5 in the Southside region. In Virginia today, older adults comprise 11 percent of people receiving Medicaid services yet drive more than 20 percent of Virginia's total Medicaid spending and 50 percent of Medicaid spending on long-term care services. As the population grows and ages in the next 20 years, many more people will become dependent on Medicare and Medicaid for health insurance coverage. //2015//

The average age of the population will increase as the baby boom generation enters retirement age. The population of Virginians age 60 and over will grow from 14.7 percent of the total population in 1990 to almost 25 percent by 2025 when there will be more than 2 million Virginians in this age group. By 2030, nearly one in every five Virginians is projected to be 65 years or older. As the Baby Boomer generation ages, the gap between male and female life expectancy is expected to narrow as a result of health advances. Women of that generation are also better educated than in the past and will be less likely to live in poverty. Some 70 percent of Virginia's seniors today live in metro areas, especially Northern Virginia, Hampton Roads and Richmond. But the localities with the highest proportion of seniors tend to be rural localities, as young people have left or retirees have moved in. Aging boomers have fewer children to care for them as they become elderly parents and grandparents. Delayed fertility and increased longevity increases the likelihood of ‘sandwich responsibilities for children of boomers- caring for their own children and their parents as well.

The number of Virginians age 85 and older will increase dramatically between 1990 and 2025 -- five times faster than the state's total population growth. This population will be predominantly female, as women have a longer life expectancy than men. As the baby boomers age, the percentage of older workers will increase as will the average age of the labor force. The senior population will have vastly different levels of needs, abilities and resources. The oldest seniors are more likely to live in poverty, to be less-educated and to have more health problems. Elderly

women significantly outnumber elderly men. Among those 85 and older, the ratio is more than two to one. Women are more likely to be widowed and to live alone and in poverty. While the senior population in Virginia is less diverse than the population overall, in the coming decades, the percent of older Virginians who are minorities will continue to grow.

In Virginia, 40 percent of grandparents are living with their own grandchildren and 6.2 percent of all children or 107,602 are being raised in a home where the grandparent is the head of household, often without a parent present at all. According to AARP, 59,464 grandparents report they are raising their grandchildren in Virginia. Of these, 40 percent are African American; 3 percent are Hispanic/Latino; 3 percent are Asian; and 52 percent are White. Grandparents raising grandchildren must establish legal custody in order to enroll grandchildren in school, access medical records and apply for benefits. The process of gaining legal custody or guardianship can be expensive, emotionally draining and confusing. These grandparents are 60 percent more likely to live in poverty than grandparents who are not responsible for children. The cost of caring for children can be overwhelming for those on a fixed income. Many grandparents make significant employment changes such as delaying retirement or quitting work sooner than planned in order to care for children.

The minority population (all who indicate they are Hispanic or a race other than white only) has grown since 1980. Approximately 48 percent of Virginia's population was born in another state or nation. New residents from other states tend to be younger, better educated and earn more than native Virginians. In 2007, there were more than 794,000 foreign-born Virginians, an increase from about 570,000 in 2000. /2014/ In 2011, there were more than 900,243 foreign-born Virginians, an increase from about 570,000 in 2000.//2014// Immigrants tended to be younger and divided between the less- and better-educated population segments. The mix of immigrants in Virginia included a higher percentage of Asians compared to the national average. Virginia's most racially and ethnically diverse communities are in Northern Virginia and the Tidewater area. In Tidewater, where the population is mostly comprised of non-Hispanic White and non- Hispanic Black, it is also home to one of the largest Asian populations in the state. While non-Hispanic Whites will continue to be the majority of Virginia's population in the next few decades, the proportion of Asians and Hispanics will grow.

Virginia's Hispanic population tripled between 1990 and 2006. Hispanics account for 6 percent of Virginia's population, compared to 15 percent nationwide. /2014/ Virginia's Hispanic population has grown by 92 percent in the last ten years. Hispanics account for 8.4 percent of Virginia's population, compared to 17 percent nationwide. //2014// Participation in the labor force (defined as currently working or actively looking for work) characterizes 68 percent of Virginians age 16 and above, and 80 percent of Hispanic immigrants. Hispanic immigrants account for 3.4 percent of Virginia's labor force. Employed in a wide range of occupations, they are concentrated in a few occupational sectors that require little education. For example, Hispanic immigrants represent nearly 15 percent of workers in construction, farming, and buildings and grounds cleaning and maintenance. Food preparation and serving also employ large numbers of Hispanic immigrants. Additionally, more than 3 percent of Virginia's military employees are Hispanic immigrants.

The distribution of Virginia's Hispanic population is highly uneven, concentrated in the state's three major metropolitan areas, and selected rural areas. In Northern Virginia, Hispanics represent more than 15 percent of the populations of Manassas Park City, Manassas City, Prince William County, and Arlington County; Fairfax County, the largest county in Virginia, is home to more than one-quarter of all of Virginia's Hispanic residents. Additionally, a number of rural localities in Virginia show a significant increase in the number of Hispanics residents. Included among them is Galax City in Southwest Virginia, with 14 percent of its population being Hispanic. Forty percent of Hispanics in Virginia are immigrants, both documented and undocumented.

/2014/ While most localities experienced significant Hispanic population increases, the majority of Virginia Hispanics live in the Urban Crescent and in some pockets of Southside Virginia and the Upper Valley. Northern Virginia is home to more than 60 percent of Virginia's Hispanics. //2014//

Hispanic immigrants are less educated, poorer, more likely to lack health insurance, and live in larger households than the overall population. Hispanics (both citizens and immigrants) received benefits and were over-represented in two social welfare programs (WIC and job training) and two public subsidy programs (rent subsidies and free-and-reduced-price school lunch). Of 17,000 job-training recipients, 7 percent were Hispanics. Hispanic households are also over-represented in uptake of rent subsidies and free and reduced priced lunch (accounting for 20 and 16 percent, respectively, of the total recipient households), but were significantly under-represented in the remaining three categories (public housing, food stamps, and energy subsidies). Hispanic immigrants and their children receive little welfare other than WIC and school lunch subsidies. Hispanic immigrants are less likely to have health insurance than the overall population. In 2006, 57 percent of Hispanic immigrants lacked health insurance, compared to 27 percent of Hispanic citizens, and 14 percent of all Virginians.

Economy

According to The Council for Virginia's Future, poverty has a significant impact on individuals and society at large. Children who live in poverty are likely to suffer from poor nutrition during infancy, experience increased emotional distress, and have an increased risk for academic failure and teenage pregnancy. Adult men and women who live in poverty are at high risk of poor health and violence. Poverty can also affect seniors' ability to care for themselves or to obtain prescription medication. Virginia had the 12th lowest poverty rate in the nation in 2008. 10.2 percent of Virginians fell below the federal poverty level, which in 2008 was $10,991 for an individual. The national average was 13.2 percent in 2008. There was an increase in the percent in poverty, from 8.74 in 2002. In 2007, poverty most affected Black (18.2 percent) and Hispanic (13.3 percent) residents compared to White residents (7.7 percent).

/2014/ According to The Council for Virginia's Future, poverty has a significant impact on individuals and society at large. Children who live in poverty are likely to suffer from poor nutrition during infancy, experience increased emotional distress, and have an increased risk for academic failure and teenage pregnancy. Adult men and women who live in poverty are at high risk of poor health and violence. Poverty can also affect seniors' ability to care for themselves or to obtain prescription medication. Virginia had the 8th lowest poverty rate in the nation in 2011 at 11.5 percent, which in 2011 was $11,484 for an individual. However, due to the 2007-2009 recession and its prolonged high joblessness, poverty rates in Virginia have been steadily rising; in fact, although many states have seen minor reductions across certain years, poverty rates on the whole have been increasing nationwide since the start of the decade. The national average was 15.9 percent in 2011. In 2007, poverty most affected Black (18.2 percent) and Hispanic (13.3 percent) residents compared to White residents (7.7 percent). //2014//

/2015/ Poverty has a significant impact on individuals and society at large. Children who live in poverty are likely to suffer from poor nutrition during infancy, experience emotional distress, and have an increased risk for academic failure and teenage pregnancy. Adult men and women who live in poverty are at high risk of poor health and violence. Poverty can also affect seniors' ability to care for themselves or to obtain prescription medication. Due to the 2007-2009 recession and its prolonged high joblessness, poverty rates in Virginia have seen small but steady increases for the past six years. In fact, although many states have seen minor reductions across certain years, poverty rates on the whole have been increasing nationwide since the start of the decade. The national average held steady at 15.9 percent in 2012. Virginia had the 9th lowest poverty rate in the nation in 2012 at 11.7 percent, a small increase from the year before. //2015//

In 2008 the Southside region had the highest percentage (18.5%) of individuals living below the poverty level of any region in the state, followed by the Southwest (18.1%) and Eastern (15.0%) regions. At the other end of the scale, the Northern region (5.4%) had the lowest percentage of individuals living below the poverty level, followed by the Central (10.7%) and Hampton Roads (11.0%) regions. Among Virginia's peers, Maryland had the lowest poverty rate at 8.1 percent,

while North Carolina and Tennessee both had higher rates of poverty at 14.6 and 15.5 percent respectively.

/2014/ In 2011 the Southside region had the highest percentage (20.5%) of individuals living below the poverty level of any region in the state, followed by the Southwest (19.4%) and Eastern (15.7%) regions. At the other end of the scale, the Northern region (6.8%) had the lowest percentage of individuals living below the poverty level, followed by the Hampton Roads (12.4%) and Central (12.5%) regions. Among Virginia's peers, Maryland had the lowest poverty rate at 10.1 percent, while North Carolina and Tennessee both had higher rates of poverty at 17.9 and 18.3 percent respectively. //2014//

/2015/ In 2012 poverty rates again rose for every region except the Northern, Central, and Southside regions -- yet Southside still had the highest percentage (20.3%) of individuals living below the poverty level of any region in the state, followed by the Southwest (20.0%) region. With poverty levels of 16 percent each, the Eastern and West Central regions didn't fare much better. At the other end of the scale, the Northern region (6.5%) had the lowest percentage of individuals living below the poverty level, followed by the Central (12.4%) and Hampton Roads (13.2%) regions. Among Virginia's peers, Maryland had the lowest poverty rate in 2012 at 10.3 percent, while North Carolina and Tennessee both had considerably higher rates -- 18.0 and 17.9 percent, respectively. New Hampshire ranked top in the nation with a poverty rate of 10.0 percent. //2015//

The percentage of children in poverty increased from 12 percent in 2000 to 13 percent in 2007. The US rate of children living in poverty for 2007 and 2008 was 18%. More recently, in 2008, 14 percent of Virginia children were living in poverty, 6 percent were living in extreme poverty; 22 percent were below 150% poverty. Thirty percent of children living in poverty were Black/African American, 8 percent were non-Hispanic white, and 16 percent were Hispanic or Latino.

/2014/The percentage of children in poverty increased from 12 percent in 2000 to 15 percent in 2011. The US rate of children living in poverty for 2011 was 23%. More recently, in 2011, 6 percent of Virginia children were living in extreme poverty; 25 percent were below 150% poverty. Twenty-eight percent of children living in poverty were Black/African American, 9 percent were non-Hispanic white, and 24 percent were Hispanic or Latino.//2014//

According to the Council for Virginia's Future, per capita personal income includes wages and salaries, transfer payments, dividends, interest, and rental income and is used as the broadest indicator of the magnitude of improvement in an economy. Rising income levels allow individuals to provide for their families, buy homes and improve the quality of their lives.

In 2008, Virginia ranked seventh among the states in per capita personal income, with $44,224 per capita income (in 2008 dollars). Relative to its peers, Virginia's per capita income was lower than Maryland, ($48,378) in 2008, but higher than North Carolina ($35,344) and Tennessee ($34,976). National per capita income stood at $40,194. Within Virginia, the Northern region had the highest per capita personal income in 2007 at $56,981 (in 2007 dollars), while the Central region had the second-highest ($39,719). At the other end of the spectrum, the Southside and Southwest regions had the lowest per capita personal income at $25,527 and $26,264, respectively.

/2014/ In 2011, Virginia ranked eighth among the states in per capita personal income, with $47,082 per capita income. Relative to its peers, Virginia's per capita income was lower than Maryland, ($51,971) in 2012, but higher than North Carolina ($37,049) and Tennessee ($37,678). National per capita income stood at $42,693. Within Virginia, the Northern region had the highest per capita personal income in 2011 at $61,136 (in 2011 dollars), while the Central region had the second-highest ($42,571). At the other end of the spectrum, the Southside and Southwest regions had the lowest per capita personal income at $29,318 and $30,754, respectively.//2014//

/2015/ In 2012, Virginia's average wage was $51,646, exceeding the national average ($49,289). New York again led all states with an average wage of $62,669 in 2012. Maryland's average wage ($54,035) was higher than Virginia, while North Carolina ($43,110) and Tennessee ($43,961) had notably lower average wages. Regionally, the Northern region's average wage of $67,763 once again led the state in 2012. The Southside ($30,093) and Southwest ($33,943) regions were again the lowest. //2015//

Between 2000 and 2008 Virginia's per capita income grew at a rate of 1.4 percent, compared to the national average of 0.7 percent over the same period. Within Virginia, Hampton Roads had the fastest growth rate at 2.2 percent between 2000 and 2007.

/2014/ Between 2002 and 2011, Virginia's per capita income grew at a rate of 0.88 percent, compared to the national average of 0.49 percent over the same period. Within Virginia, the Eastern region had the fastest growth rate at 1.54 percent between 2002 and 2011. //2014//

/2015/ Between 2003 and 2012, Virginia's per capita income grew at a rate of 0.94 percent, compared to the national average of 0.62 percent over the same period. Within Virginia, the Eastern region had the fastest growth rate at 1.67 percent between 2003 and 2012. //2015//

Median household income has increased from $36,367 in 1995 to $61, 210 in 2008. The US median household income has increased from $50,800 in 2004 to $58,900. The median family (with child) income was $69,400 in 2008, up from $57,200 in 2004. The number of households receiving Food Stamps has increased from 160,345 in 2002 to 253,273 in 2008. The TANF rates increased from 46 TANF recipients per 1,000 children in 1998 to 111 per 1,000 children in 2008.

Employment
According to Virginian Performs, employment growth is an indicator of expansion in the economy and represents an increase in the economic opportunities available to the citizens of a region or state. Employment growth is generally tracked as a percentage change from a previous year. Between 2000 and 2005, Virginia's employment grew at a faster rate than the national average but it lagged U.S. growth during 2006-2008. Virginia's 2007-08 employment growth rate of 1.04 percent exceeded Tennessee (0.71 percent) but was slightly slower than Maryland (1.12 percent) and North Carolina (1.06 percent). Regional employment growth data in 2007 indicate that the Northern region (2.71 percent) had the fastest growing rate in the state over the previous year. The Central region exhibited the second highest employment growth at 2.64 percent, while the West Central region registered 1.76 percent employment growth. Virginia's remaining regions all saw rates at or below 1.64 percent.

/2014/ According to Virginian Performs, employment growth is an indicator of expansion in the economy and represents an increase in the economic opportunities available to the citizens of a region or state. Employment growth is generally tracked as a percentage change from a previous year. Between 2000 and 2005, Virginia's employment grew at a faster rate than the national average but it lagged U.S. growth during 2006-2007. As the nation entered recession in 2008, Virginia's employment growth rate turned negative, as it did in most states. Its rate of decline was less severe during the recession (-2.22% in 2009 and -0.21% in 2010) than the nation as a whole (-3.02 and -0.34% respectively). However, although Virginia employment grew again in 2011 (0.99%), it slightly lagged U.S. growth (1.27%). Virginia's employment growth rate was also lower than all its peer states: Maryland (1.17%), North Carolina (1.26%), and Tennessee (1.51%). Regional employment growth data in 2011 indicate that the Northern region (1.72 percent) had the fastest growing rate in the state over the previous year followed by the Central (1.28) and Valley (1.19) regions. The Eastern and Southside regions experienced employment losses while growth was minimal in the remaining regions.//2014//

/2015/ Virginia employment grew again in 2011 (1.19%) and 2012 (1.13%), it lagged overall U.S. growth (1.24% and 1.77%). Virginia's employment growth rate was also lower than its

peer states in 2012: Maryland (1.34%), North Carolina (1.79%), and Tennessee (1.95%). Many economists attribute this sluggish increase in the employment rate in part to the federal sequestration implemented at the start of 2012, where significant across-the-board cuts in spending have affected many state economies. Given its extensive military infrastructure and the Northern region's role as part of the Washington, D.C. metropolitan area, Virginia is seen as especially vulnerable. Regionally speaking, employment growth rates in 2012 were positive for all but three areas. The Central region grew at the fastest rate (1.79%), followed by the Northern (1.45%) and West Central (1.18%) regions. The Eastern, Southwest, and Southside regions experienced employment losses. //2015//

In 2006-2008, for the employed population 16 years and older, the leading industries in Virginia were educational services, and health care, and social assistance (20 %), and professional, scientific, and management, and administrative and waste management services, (14 %). Among the most common occupations were: management, professional, and related occupations (40 %), sales and office occupations (24 %), service occupations (15 %) production, transportation, and material moving occupations (10 %) and construction, extraction, maintenance and repair occupations (10 %). Seventy-four percent of the people employed were private wage and salary workers; and 20 percent were federal, state, or local government workers.

Unemployment is a measure of how many people without jobs are actively seeking employment. According to Virginia Performs, since most people earn a living through a job, unemployment is also a measure of how the economy is doing in providing opportunities for Virginians to support themselves and their families. Unemployment not only hurts the personal finances of those without jobs, but also reduces their participation in the overall economy. The inability to find work is also associated with psychological stress, health problems, and stress on family relationships. Only people who have jobs or who are actively seeking one are part of the labor force; unemployed people who have stopped looking for a job are no longer counted as members of the labor force.

In 2008, Virginia, with a 4.0 percent unemployment rate, ranked ninth among the states. South Dakota had the lowest unemployment rate at 3.0 percent. Virginia's 2008 rate was lower than its peers, North Carolina (6.3%), Tennessee (6.4%) and Maryland (4.4%), and lower than the national rate of 5.8 percent. Across the state, the unemployment rate varied in 2008 from a high of 7.2 percent in the Southside region to a low of 3.0 percent in the Northern Region. The central tier of the state (Central and West Central regions) had rates between 4.2 percent and 4.3 percent. The Southwest region was second highest with 5.4 percent unemployment. In the last decade, the Southside and Southwest regions have routinely experienced higher rates of unemployment than other regions, largely due to the loss of manufacturing jobs and limited economic growth. More recently, the Virginia unemployment rate for December 2009 was 6.7 percent, an increase of 1.6 percent from December 2008 (5.1%). Virginia's rate is lower than the US rate of 9.7 percent.

/2014/ In 2012, Virginia, with a 5.9 percent unemployment rate, ranked 13th among the states. North Dakota had the lowest unemployment rate at 3.1 percent. Virginia's 2012 rate was lower than its peers, North Carolina (9.5%), Tennessee (8.0%) and Maryland (6.8%), and lower than the national rate of 8.1 percent. Across the state, the unemployment rate varied in 2012 from a high of 9.2 percent in the Southside region to a low of 4.5 percent in the Northern Region. The central tier of the state (Central and West Central regions) had rates between 6.2 percent and 6.4 percent. The Southwest region was second highest with 7.8 percent unemployment. In the last decade, the Southside and Southwest regions have routinely experienced higher rates of unemployment than other regions, largely due to the loss of manufacturing jobs and limited economic growth. //2014//

Examination of Virginia's unemployment by industry reveals that certain fields, such as construction, administrative and waste services, accommodation and food services, manufacturing, and health care and social assistance, have relatively higher rates of

unemployment. Financial services, government, transportation, and education and health care have relatively lower unemployment rates than other industries in the state. /2014/ Examination of Virginia's unemployment by industry reveals that certain fields, such as construction, information services, manufacturing, and leisure and hospitality, have relatively higher rates of unemployment. However, additional fields have recently seen higher unemployment than in earlier years -- trade and professional and business services among them. Financial services, government, and education and health care have relatively lower unemployment rates than other industries in the state. //2014//

/2015/ In 2012, manufacturing, IT services, and even construction saw significant decreases in unemployment, while those in the transportation and utilities field experienced unemployment rates just under 4 percent. //2015//

There were 330 mass layoff events in the state in 2009; representing a 184.5% increase from 2008. Total unemployment insurance claimants increased from 42,809 in 2005 to 104,212 in 2009. In 2007, 27 percent of children were living in families where no parent has a full-time, year-round employment and 3 percent were living in low-income households where no adults work. In 2008, 63 percent of teens ages16 to 19 were unemployed.

Health

Virginia is 21st in health this year, unchanged from 2008. Strengths include a low prevalence of smoking at 16.4 percent of the population, a low violent crime rate at 256 offenses per 100.000 population, ready availability of primary care physicians with 125.0 primary care physicians per 100,000 population and few poor mental health days per month at 3.0 days in the previous 30 days. Virginia ranks higher for health determinants than for health outcomes, indicating that overall healthiness should improve over time. Challenges include high levels of air pollution at 12.1 micrograms of fine particulate per cubic meter, low immunization coverage with 73.2 percent of children ages 19 to 35 months receiving complete immunizations and high geographic disparity within the state at 14.9 percent. In the past year, the rate of preventable hospitalizations decreased from 70.2 to 64.8 discharges per 1,000 Medicare enrollees. In the past five years, the prevalence of smoking decreased from 22.0 percent to 16.4 percent of the population. In the past ten years, the rate of deaths from cardiovascular disease decreased from 361.4 to 282.1 deaths per 100,000 population. Since 1990, the prevalence of obesity increased from 9.9 percent to 25.5 percent of the population. In Virginia, obesity is more prevalent among non-Hispanic blacks at 34.3 percent than non-Hispanic whites at 24.0 percent. The WIC data on children shows the significant increasing trend in overweight and obesity. In 2001, 17.4% WIC children were overweight or obese as compared to 33.5% in 2009. This is just one specific population, but the data highlights the increasing overweight and obesity for all children. The prevalence of diabetes also varies by race and ethnicity in the state; 14.9 percent of non-Hispanic blacks have diabetes compared to 7.0 percent of non-Hispanic whites. In addition, mortality rates vary in Virginia, with 1,012.4 deaths per 100,000 population among blacks compared to whites, who experience 791.6 deaths per 100,000 population.

/2014/ Virginia is the 21st healthiest state this year. Strengths include low percentage of children in poverty at 14.3 percent of persons 18 and under, a low violent crime rate at 213 offenses per 100,000 population,and few poor mental health days per month at 3.4 days in the past 30 days. Virginia ranks higher for health determinants than for health outcomes, indicating that overall healthiness should improve over time. Challenges include high geographic disparity within the state at a standard deviation of 0.6 in overall mortality among counties, high prevalence of obesity and diabetes at 29.2 percent and 10.4 percent respectively, and low immunization coverage at 88.8 percent of children ages 19 to 35 months receiving complete immunizations. In the past 5 years, the rate of preventable hospitalizations decreased from 70.2 to 58.3 discharges per 1,000 Medicare enrollees. In the past five years, air pollution decreased from 12.6 to 9.7micrograms of fine particulate matter per cubic meter. In the past ten years, the rate of uninsured population increased 33 percent from 10.3 percent to 13.7 percent of the adult population. Since 1990, the prevalence of obesity increased from 9.9 percent to 29.4 percent of

the population. In Virginia, obesity is more prevalent among non-Hispanic blacks at 38.1 percent than non-Hispanic whites at 25.1 percent. The WIC data on children shows the significant increasing trend in overweight and obesity. In 2001, 17.4% WIC children were overweight or obese as compared to 33.5% in 2009. This is just one specific population, but the data highlights the increasing overweight and obesity for all children. The prevalence of smoking also varies by race and ethnicity in the state; 27.4 percent of Hispanics smoke compared to 18.0 percent of non-Hispanic blacks and 17.9 percent of non-Hispanic whites. //2014//

Some other health status indicators that highlight the challenges that Virginia faces include unintentional injuries, birth outcomes, and births to teens. Injuries took the lives of 3,929 Virginians in 2008, making this the third leading cause of death. Motor vehicle crashes accounted for approximately 1 out of every 5 of these fatalities. Although there is a continuing decline in child deaths, the leading cause of death for Virginia children is injury. Violent and abusive behavior has been increasingly recognized as an important public health issue. In 2008, 374 people were homicide victims in Virginia. Of the 374 homicides, the majority died by firearm. Approximately 18 percent of all the deaths in the 15 to 19 year-olds were classified as homicides in 2008. Homicide disproportionately affects young African American males. Fifty-nine youth ages 10-19 died from self-inflicted injuries in 2008.

The racial disparity in a number of health status indicators also presents significant challenges. For example, the infant death rate is often used as a state health status indicator. In 2008, the rate was 6.7 per 1,000 live births, down from 7.7 in 2007. However, there continues to be a large disparity between the rates for white non-Hispanic and for black non-Hispanic infants. In 2008, the infant death rate for white non-Hispanic infants was 5.1/1,000 as compared to 12.1/1,000 for black non-Hispanic infants. Low birth weight is an indicator of limited access to health care and a major predictor of infant mortality. In 2008, 8.3 percent of births were low birth weight infants. This represents a significant increasing trend since 1999. The rate of births to teens aged 15 through 17 years old has decreased from 24.9/1,000 in 1999 to 15.4/1,000 in 2008.

/2014/The racial disparity in a number of health status indicators also presents significant challenges. For example, the infant death rate is often used as a state health status indicator. In 2008, the rate was 6.7 per 1,000 live births, down from 7.7 in 2007. However, there continues to be a large disparity between the rates for white non-Hispanic and for black non-Hispanic infants. In 2008, the infant death rate for white non-Hispanic infants was 5.1/1,000 as compared to 12.1/1,000 for black non-Hispanic infants. Low birth weight is an indicator of limited access to health care and a major predictor of infant mortality. In 2008, 8.3 percent of births were low birth weight infants. This represents a significant increasing trend since 1999. The rate of births to teens aged 15 through 17 years old has decreased from 24.9/1,000 in 1999 to 15.4/1,000 in 2008.//2014//

Health Insurance

Families USA estimates that more than 10 working-age Virginians die each week due to lack of health insurance (approximately 550 people in 2006). /2014/ Families USA estimates that 11 working-age Virginians die each week due to lack of health insurance (approximately 572 people in 2010). //2014// Between 2000 and 2006, the estimated number of adults between the ages of 25 and 64 in Virginia who died because they did not have health insurance was more than 3,200. /2014/ Between 2005 and 2010, the estimated number of adults between the ages of 25 and 64 in Virginia who died because they did not have health insurance was more than 2,706. //2014// According to Virginia Performs, estimates of uninsurance in Virginia over the past several years have ranged from 10 percent to 15 percent of the total population; the range is due to differences in survey methodology, changes in policies and demographics, and fluctuations in the economy. Based on U.S. Census Bureau estimates, the national average for uninsured people was 15.4 percent in 2008. In the same year, Virginia's rate was 12.4 percent, ranking it 22nd among all states. /2014/ Based on U.S. Census Bureau estimates, the national average for uninsured people was 17.9 percent in 2011. In the same year, Virginia's rate was 15.3 percent, ranking it 21st among all states. //2014// According to the 2007 National Survey of Children's Health, about

93 percent of Virginia's children ages 0-17 were currently insured, higher than the US rate of 91 percent. About 12 percent of those surveyed reported lacking consistent insurance coverage in past year, lower than the US rate of 15 percent. /2014/ According to the 2011/2012 National Survey of Children's Health, about 94.7 percent of Virginia's children ages 0-17 were currently insured, comparable to the US rate of 94.5 percent. About 10.8 percent of those surveyed reported lacking consistent insurance coverage in past year, lower than the US rate of 11.3 percent. //2014//

In comparison with its peers, Virginia had a lower percentage of uninsured individuals than North Carolina (15.4%) and Tennessee (15.1%) but a higher one than Maryland (12.1%). The Eastern (20.2 percent), Valley (16.9), Southwest (16.1), West Central and Northern (16.0), and Southside (15.7) regions exceeded this statewide average. The Hampton Roads region had the lowest rate at 13.7. The private sector, which insures about 68 percent of the population, provides insurance for families of workers and their dependents but does not cover the cost of long-term care. The public sector -- through Medicare at the federal level and Medicaid at the state level -- provides insurance for about 22 percent of the population, with services targeted to vulnerable persons including the poor, elderly and disabled. From FY 2007 to FY 2008, enrollment in Virginia's FAMIS/SCHIP program increased from 80,024 children to 85,977 children. Medicaid enrollment increased from 649,903 to 665,800 during the same period. The rate of Virginians dependent on Medicaid has increased from 7 to nearly 9 percent over the past five years. About 8 percent of the population covers medical insurance out of their own pockets. The remaining 12 percent of the population is uninsured. /2014/ In comparison with its peers, Virginia had a lower percentage of uninsured individuals than North Carolina (18.8%) and Maryland (15.6%) but a higher one than Tennessee (15%). The Southside (18.6 percent), Eastern (18.1), and Southwest (17.3) regions exceeded this statewide average. The Northern region had the lowest rate at 13. The private sector, which insures about 58 percent of the population (a drop of almost 10 percentage points since 2001), provides insurance for families of workers and their dependents but does not cover the cost of long-term care. The public sector -- through Medicare at the federal level and Medicaid at the state level -- provides insurance for about 17 percent of the population, with services targeted to vulnerable persons including the poor, elderly and disabled. From FY 2007 to FY 2011, enrollment in Virginia's FAMIS/SCHIP program increased from 80,024 children to 103,590 children. Medicaid enrollment increased from 649,903 to 804,186 during the same period. The rate of Virginians dependent on Medicaid has increased from 8 to 10 percent over the past five years. About 7 percent of the population covers medical insurance out of their own pockets. The remaining 18 percent of the population is uninsured.//2014//

/2015/ In comparison with its peers, Virginia had a lower percentage of uninsured individuals than North Carolina (20.2%) and Tennessee (16.1%), but a bit higher than Maryland (14.1%). Massachusetts, which in 2006-07 began mandating that every state resident acquire healthcare coverage, again had the lowest uninsured rate -- 4.9 percent -- in the nation. In 2011, the Southside (17.7 percent), Eastern (17.5 percent), and Valley (17.2 percent) regions had the highest uninsured percentages. The Northern region had the lowest rate at 12.4 percent uninsured. The regional statewide average for uninsured persons under the age of 65 was 14.3 percent. The private sector currently insures about 58 percent of the population (a drop of nearly 10 percentage points since 2001). This insurance covers families of workers and their dependents but does not cover the cost of long-term care. The public sector -- through Medicare at the federal level and Medicaid at the state level -- provides insurance for about 19 percent of the population, with services targeted to vulnerable persons including the poor, elderly and disabled. From FY 2007 to FY 2012, enrollment in Virginia's FAMIS/SCHIP program increased from 80,024 children to 110,149 children. Medicaid enrollment increased from 649,903 to 834,836 during the same period. The rate of Virginians dependent on Medicaid has increased from 8 to 11 percent over the past five years, thanks largely to the recent recession and continued slow job growth. //2015//

According to Virginia Health Care Foundations' Profile of the Uninsured, the vast majority of the

uninsured (80%) live in households with at least one full-time (65%) or part-time (15%) worker. /2014/ According to Virginia Health Care Foundations' Profile of the Uninsured, the vast majority of the uninsured (70%) live in households with at least one full-time (47%) or part-time (22%) worker. //2014//Forty-six percent of uninsured Virginians live in households with a worker employed by a small company (100 or fewer employees) or with a self-employed worker. In contrast, less than 8 percent of those in companies with 500 employees or more are uninsured. Only one in four uninsured Virginians (26.8%) lives in households that have an offer of employer-sponsored health insurance. The overwhelming majority of Virginians without insurance are U.S. citizens (81%). Fifty percent of uninsured Virginia adults are Caucasian/non-Hispanic, 20 percent are African-American, 20 percent are Hispanic, and 10 percent classify themselves as "other." /2014/The overwhelming majority of Virginians without insurance are U.S. citizens (79%). 47 percent of uninsured Virginia adults are Caucasian/non-Hispanic, 24 percent are African-American, 20 percent are Hispanic, and 7 percent classify themselves as "other." //2014//

Housing

According to the 2000 Census, Virginia's home ownership rate was 68 percent, slightly higher than the US (66 %). /2014/ In 2011, Virginia's home ownership rate was 67 percent, slightly higher than the US (65 %)//2014// The downturn in Virginia's economy has impacted home foreclosures. In April 2010, 1 in 467 Virginia housing units received a foreclosure filing notice. Fairfax and Prince William had the highest number of units receiving a notice in April. ***/2015/ In February 2012, Virginia had the 24th highest foreclosure rate in the nation with 1 in every 1,097 housing units having a foreclosure filing. Fairfax and Prince William had the highest number of unites receiving a foreclosure filing notice. //2015//*** The population per household was 2.54 and 3.2 percent lived in crowded housing. Less than 1 percent of occupied units lacked complete plumbing or complete kitchen. A housing unit is considered crowded if there is more than 1 person per room. In 2008, 7 percent of Virginia's children lived in crowded housing; 13 percent of these children were in immigrant families. For the same year, the national rate of children living in crowded housing was 13 percent. In 2008, 66 percent of Virginia's children lived in low-income households where housing costs exceeded 30 percent of income; the same rate as in the US. Forty-nine percent were children in immigrant families, roughly the same percent (51%) as for the US. /2014/ In 2011, 8 percent of Virginia's children lived in crowded housing; 17 percent of these children were in immigrant families. For the same year, the national rate of children living in crowded housing was 14 percent. In 2011, 69 percent of Virginia's children lived in low-income households where housing costs exceeded 30 percent of income; slightly higher than the national rate (66%). Forty-six percent were children in immigrant families, roughly the same percent (51%) as for the US. //2014// According to the 2007 National Survey of Children's Health, with respect to neighborhood amenities, 44.9 percent of Virginia children live in neighborhoods with a park, sidewalks, a library, and a community center compared to 48.2 percent of US children. Eleven percent of Virginia children live in neighborhoods with poorly kept or dilapidated housing, lower than the US rate of 14.6 percent. Eighty-three percent of children live in supportive neighborhoods, about the same as the national rate (85%). Almost ninety percent live in neighborhoods that are usually or always safe, higher than the US rate (86.1 %). /2014/ According to the 2011/2012 National Survey of Children's Health, with respect to neighborhood amenities, 53 percent of Virginia children live in neighborhoods with a park, sidewalks, a library, and a community center, similar to the national rate of 54. Nine percent of Virginia children live in neighborhoods with poorly kept or dilapidated housing, lower than the US rate of 16.2 percent. Eighty-six percent of children live in supportive neighborhoods, about the same as the national rate (82%). Almost ninety-one percent live in neighborhoods that are usually or always safe, higher than the US rate (86.6 %). //2014//

Education

According to Virginia Performs, the high school graduation rate is one measure of the success of a state's elementary and secondary educational system and the quality of its workforce. Completion of high school or its equivalent is increasingly the minimum level of education sought by employers; moreover, unemployment rates are lower and lifetime earnings are substantially higher for high school graduates than for high school dropouts. Graduation rates improved for

each of Virginia's regions in 2008-2009 compared to 2007-2008 with the statewide average increasing from 82.2 percent to 83.2 percent. The Northern region (87.8%) has a rate that exceeds the statewide average, while the Southwest (83%), Valley (82.9%), Southside and Central (82.3%), West Central (81.3%), Hampton Roads (80.6%), and Eastern region (78.1%) have graduation rates that are below the statewide average. /2014/ According to Virginia Performs, the high school graduation rate is one measure of the success of a state's elementary and secondary educational system and the quality of its workforce. Completion of high school or its equivalent is increasingly the minimum level of education sought by employers; moreover, unemployment rates are lower and lifetime earnings are substantially higher for high school graduates than for high school dropouts. Graduation rates continued to improve for nearly all of Virginia's regions in 2011-2012 compared to 2007-2008 with the statewide average increasing from 82.1 percent to 88.0 percent. The Northern (90.7%) and Valley (88.6%) regions have rates that exceed the statewide average, while the Central (87.8%), Southwest (87.2 %), Eastern (86.7%), West Central (86.4%), Hampton Roads (85.9%), Hampton Roads (80.6%), and Southside region (85.6%) have graduation rates that are below the statewide average. //2014//

/2015/ Graduation rates continued to improve for nearly all of Virginia's regions in 2012-2013 compared to 2007-2008 with the statewide average increasing from 82.1 percent to 89.1 percent. The Northern (91.6%) and Valley (91.0%) regions have rates that exceed the statewide average. And although below the state average, the remaining regions all saw improvement in their graduation rates: Central (88.7%), Southwest (89.0 %), Eastern (87.8%), West Central (87.7%), Hampton Roads (87.0%), and Southside (86.5). //2015//

The student dropout rate has declined over time from 2.2 percent in 2002 to 1.9 percent in 2007. In 2008, 4 percent of teens were high school dropouts, down from 7 percent in 2004. In 2009, the dropout rate for Hispanic/Latino youth was 10 percent, for black non-Hispanic the rate was 3 percent and for white non-Hispanic the rate was 3 percent. The US rate for dropouts was 6 percent in 2008. /2014/ The student dropout rate declined over time from 3.9 percent in 2000 to 2.5 percent in 2009. In 2012, 6.5 percent of teens were high school dropouts, down from 7.2 percent in 2011. In 2009, the dropout rate for Hispanic/Latino youth was 17 percent, for black non-Hispanic the rate was 9 percent and for white non-Hispanic the rate was 4 percent. The US rate for dropouts was 4.1 percent in 2009.//2014//

/2015/ Based on data from the National Center for Education Statistics, Virginia's high school dropout rates have decreased in recent years, falling from 3.5 percent in 2001 to 2.1 percent in 2010; Virginia had the 8th lowest dropout rate in the country. //2015//

/2014/ Virginia's educational attainment is slightly above the national average in terms of individuals with a high school education, but well above average for individuals with higher education. In 2008, Virginia ranked 30th in the nation for the highest percentage of its adult population (25 years or older) with at least a high school degree, but 6th for adults with at least a bachelor's degree. /2014/ In 2011, Virginia ranked 27th in the nation for the percentage of its adult population (25 years or older) with at least a high school degree, but 7th for adults with at least a bachelor's degree. //2014//

/2015/ In 2012, Virginia ranked 29th in the nation for the percentage of its adult population (25 years or older) with at least a high school education, but 7th for adults with at least a bachelor's degree. //2015//

In Virginia, 85.9 percent of adults had at least a high school degree in 2008, exceeding the national average of 85.0 percent. Neighboring states Tennessee (83.0%), North Carolina (83.6%), and Maryland (88.0%) also performed well, but Wyoming led the nation at 91.7 percent high school graduation. The percentage of Virginia's adult population with at least a bachelor's degree increased from 31.7 percent in 2002 to 33.7 percent in 2008, exceeding the national rate of 27.7 percent. Comparing rates of individuals with at least a bachelor's degree, Virginia is behind Maryland's rate of 35.2 percent, but above North Carolina (26.1%) and Tennessee

(22.9%). Massachusetts led the states in 2008 with a rate of 38.1 percent of residents with a bachelor's degree or above. Educational attainment increased in every region across Virginia between 1990 and 2000. All regions increased both their high school- and college-educated population, with the Northern and Hampton Roads regions having the highest high school-educated population, and the Northern and Central regions having the highest college-educated populations.

/2014/ In Virginia, 87.8 percent of adults had at least a high school degree in 2011, exceeding the national average of 85.9 percent. Virginia's rate was higher than neighboring states Tennessee (84.2%) and North Carolina (84.7%), but lower than Maryland (88.9%). Montana led the nation at 92.3 percent high school graduation. The percentage of Virginia's adult population with at least a bachelor's degree increased from 31.7 percent in 2002 to 35.1 percent in 2011, exceeding the national rate of 28.5 percent. Comparing rates of individuals with at least a bachelor's degree, Virginia is behind Maryland's rate of 36.9 percent, but above North Carolina (26.9%) and Tennessee (23.6%). Massachusetts led the states in 2011 with a rate of 39.1 percent of residents with a bachelor's degree or above. Educational attainment increased in every region across Virginia between 2000 and 2007-2011. All regions increased both their high school- and college-educated population, with the Northern and Hampton Roads regions having the highest high school-educated population, and the Northern and Central regions having the highest college-educated populations. //2014//

/2015/ 87.9 percent of Virginia adults had completed at least high school in 2012, exceeding the national average of 86.4 percent. Virginia's rate was higher than neighboring states Tennessee (85.1%) and North Carolina (85.2%), but lower than Maryland (89.1%). Montana again led the nation with 92.8 percent of its adult population with at least a high school education. The percentage of Virginia's adult population with at least a bachelor's degree has exceeded the national average for many years. It has increased from 32.2 percent in 2003 to 35.5 percent in 2012; the national average in 2012 was 29.0 percent. Comparing rates with peer states, Virginia still lags behind Maryland's rate of 36.9 percent, but above North Carolina (27.4%) and Tennessee (24.3%). Massachusetts again led the nation in 2012 with 39.3 percent of residents with a bachelor's degree or above. Educational attainment improved in every region across Virginia between 2000 and 2012. All regions increased both their high school- and college-educated populations, with the Northern and Hampton Roads regions having the highest high school-educated populations, and the Northern and Central regions having the highest college-educated ones. There has, however, been a slight drop-off in attainment in two regions compared to last year's survey results (not included on graph due to space limitations): The Valley region lost 2.3 percentage points for residents with at least high school completion and 2 points in college attainment; the Southwest region dropped 0.3 percentage points for residents with a bachelor's degree or better. //2015//

Agency Accountability and Strategic Planning
House Bill 2097, passed by the 2003 General Assembly, requires that each state agency implement a state performance-based budgeting system. Since that time, an ad hoc advisory group of agency representatives designed the new planning and budgeting model that requires all state agencies to have strategic plans that are tied to their budget and use common language and format. The planning process was unveiled to agency heads by Governor Warner in December 2004. Since that time state agencies, including VDH, have developed their strategic plans and area service plans (operational plans) that are tied to the strategic plan and budgets. This significant change in state government planning and budgeting creates a greater transparency in government by making public how tax payer dollars are spent and the return on investment.

As a result, the VDH strategic plan identified 41 service areas and developed a service area plan for each. The following four service areas are related to state Title V activities:
Women's and Infants' Health

Injury and Violence Prevention
Child and Adolescent Health
Chronic Disease Prevention, Health Promotion and Oral Health

VDH monitors a series of agency performance measures that are tied to the service areas and are publicly reported on the Virginia Performs website http://vaperforms.virginia.gov/

The VDH Strategic Plan, including MCH related components, is available on the web at http://www.vdh.virginia.gov/Administration/StrategicPlan/.

State MCH Priorities
The Virginia Title V program staff collaborate with a number of agencies within the Virginia Secretariat of Health and Human Resources (SHHR) to identify and jointly address the needs of the MCH populations. Regular meetings with other agencies, cross-agency program development, workgroups and special taskforces assist in the identification of issues and the prioritization of Title V efforts. These agencies within the SHHR include the Department of Behavioral Health and Developmental Services, formerly the Department of Mental Health, Mental Retardation and Substance Abuse Services, the Department of Social Services, the Department of Medical Assistance Services, the Department of Health Professions, and others. In addition, collaborative meetings with agencies outside the SHHR include the Department of Education, the Joint Commission on Health Care, the Commission on Youth and various legislative committees. Title V program staff also collaborate with and seek input from professional organizations, consumer representatives, advocacy groups and community providers as well as internally with offices within the VDH such as the Office of Minority Health and Public Health Policy, and the Division of STD/AIDS within the Office of Epidemiology.

For the FY 2011 needs assessment OFHS initiated special efforts to involve our external partners in setting the MCH priorities. The needs assessment process included the collection of qualitative data through focus groups, key stakeholder interviews and a survey of district health department nurse managers. In addition, Marjory Ruderman, a consultant affiliated with Johns Hopkins University, facilitated priority setting meetings of OFHS staff and external stakeholders. During the meetings the MCH priorities were developed based on the presentation of needs assessment data and the needs identified by participants along with some overarching principles to guide our approach to addressing the needs of Virginia's families over the next five years. These overarching principles include continuing to recognize and address health disparities and the social determinates of health, continuing to use a socio-ecological approach to health that addresses social and environmental determinants and promotes safe and healthy communities, increasing family involvement, increasing workforce capacity for medical, dental, mental health and nontraditional providers, making resources available for both providers and families, and continuing to focus program planning and strategy development on the life course perspective. These overarching principles will inform our work in addressing the MCH priorities.

The 2011 Title V needs assessment process served as an essential tool to reflect on system changes and examine the health status of Virginia's families. Although there have been improvements in some areas, there continue to be disparities based on race, income, age, insurance coverage and areas of the state. These variations continue to present challenges. During the next year, the Title V efforts will continue to focus on 1) reducing infant mortality; 2) reducing injuries, violence, and suicide among Title V populations; 3) increasing access to dental care and population-based prevention of dental disease across the lifespan; 4) decreasing childhood obesity; 5) decreasing childhood hunger; 6) improving access to health care services for CYSHCN; 7) promoting independence of young adults with special health care needs; and, 8) supporting optimal child development.

More detailed MCH-related health status indicators are reported in the FY 2011 Needs Assessment. Virginia's MCH priorities are listed in Section IV of this application. In addition, other emerging health trends, problems, gaps and barriers are also identified in the Needs

Assessment.

B. Agency Capacity

The Office of Family Health Services (OFHS) within the Virginia Department of Health has responsibility for the development and implementation of the MCH Block Grant. The mission of Virginia's MCH efforts is to protect, promote and improve the health and well-being of women, children and adolescents, including those with special health care needs. Major goals include improving pregnancy and birth outcomes, improving the health of children and adolescents, including those with special health care needs, assuring access to quality health care services, eliminating barriers and health disparities and strengthening the MCH infrastructure. The Office of Family Health Services is comprised of the divisions of Women's and Infants' Health, Child and Adolescent Health, Dental Health, Physical Activity, Nutrition and Food Programs, Chronic Disease Prevention and Control and Injury and Violence Prevention. The director of the OFHS is Diane Helentjaris, M.D., M.P.H. She was appointed effective May 25, 2010 following the retirement of David Suttle, M.D. (See attached list of Virginia Code sections related to the provision of maternal and child health services).

MCH programs and services in Virginia are provided at each of the four levels of the MCH pyramid to protect and promote the health of women and children, including those with special health care needs. The programs and services are funded by Title V, Title X, a number of federal categorical grants and state funds. OFHS continues to have strong relationships with organizations and other state and local agencies that address the needs of the maternal and child population. These include organizations such as the Virginia Chapter of the American Academy of Pediatrics, the Medical Society of Virginia, the Virginia Dental Association, free clinics, community health clinics, parent organizations, medical centers, Virginia Department of Medical Assistance Services, Virginia Department of Social Services, Virginia Department of Behavioral Health and Developmental Services, Virginia Department of Education, local school districts, and others.

The Division of Women's and Infants' Health (DWIH) assesses and advocates for the health needs of infants and of women, particularly women of childbearing age. Joan Corder-Mabe, R.N.C., M.S., W.H.N.P., serves as the division director. Title V, state funds and federal categorical grant funds, including Title X Family Planning funds, support the division work. The breast and cervical cancer screening program, Every Woman's Life (EWL), provides breast and cervical cancer screening, referral and follow-up to low income Virginia women. In 2008, Virginia was awarded a CDC grant to establish a WISEWOMAN program as a part of the EWL program. The program provides lifestyle counselors that provide health screenings, counseling, materials, education and referrals to community resources. The screenings include blood pressure, glucose, cholesterol measurement as well as assessing weight, medical history, tobacco use, adequate diet and physical activity. The WISEWOMAN program works closely with the Division of Chronic Disease and Control's Heart Disease and Stroke Prevention program, Diabetes Prevention and Control program and the Tobacco Use Control project. The division also provides comprehensive family planning services in local health departments (supported by Title X grant funds) to assist low-income women to plan and space their pregnancies. In the past, the Voluntary Sterilization program, managed by the DWIH, has utilized state funds to provide permanent birth control methods to low income individuals, male and female, age 21 and over, who wish to conclude their ability to reproduce children. A number of local health departments use Title V funds to provide prenatal care. Several programs aim at reducing infant mortality and morbidity through home visiting, regional coalition activities (Regional Perinatal Councils), mentoring pregnant teens (Resource Mothers), nutrition counseling, nurse case management, fetal and infant mortality reviews (FIMR), community-based projects and public and professional education. The Virginia Healthy Start program "Loving Steps", is administered in this division. The goal of "Loving Steps"

is to reduce health disparities within the African American population in order to improve birth outcomes. Virginia's federally funded Healthy Start Initiative, which began in 1997, currently serves two urban areas, Norfolk and Petersburg, and one rural area, Westmoreland County. These communities were chosen because of their higher than average infant mortality and low birth weight rate along with a high rate of births to teens and their high rates of poverty and other risk factors. Loving Steps provides at-risk pregnant women, inter-conceptual women and at risk infants and toddlers with case management, health education, inter-conceptual care, and perinatal depression screening using the Edinburgh Postnatal Depression Scale. Loving Steps also works closely with the Resource Mothers program, the Regional Perinatal Councils and the Fetal/Infant Mortality Review (FIMR) program to improve birth outcomes. The Sickle Cell program coordinates the follow-up of newly diagnosed newborns with sickle cell disease and includes public and family education, testing and counseling regarding the disease. In addition, DWIH staff participates in the Maternal Mortality Review Team that is located in the Virginia Department of Health's Office of the Chief Medical Examiner.

The Division of Child and Adolescent Health's (DCAH) mission is to give children, including children with special health care needs, a healthy start in life and help them maintain good health in the future. Joanne Boise, R.N., M.S.P.H., serves as the division director. The DCAH mission is accomplished through assessing health data, identifying resources, informing the public about child and adolescent health issues, assisting policy makers, supporting private and public health care providers, developing and implementing programs and information systems, identifying resources, providing clinical consultation and educational activities, and developing and distributing guidelines and educational materials. Programs administered in the division include the Teen Pregnancy Prevention Initiative, Newborn Screening Services, Early Hearing Detection and Intervention Program, Virginia Congenital Anomalies Reporting and Education System (birth defects registry), Early Childhood and School Age Health, Child Development Clinics, Bleeding Disorders Program, and Care Connection for Children. Staff co-lead Bright Futures Virginia, most recently overseeing the development of the Bright Futures-based web portal for parents, www.healthyfuturesva.com. In addition, division staff participates on the Part C Interagency Coordinating Council, the State and Local Advisory Team for the Comprehensive Services Administration, and the Foster Care Health Plan Work Group. The Childhood Lead Poisoning Prevention program originally was housed in the DCAH, but was transferred to the Office of Environmental Health within VDH. Collaborative efforts relating to lead poisoning prevention continue between the Office of Environmental Health and the DCAH.

The Children with Special Health Care Needs (CSHCN) program is located within the DCAH and consists of Care Connection for Children, the Child Development clinics and the Bleeding Disorders Program. Nancy Bullock, R.N., M.P.H. is the director of the CSHCN program. The Care Connection for Children program is the statewide network of centers of excellence for children with special health care needs (CSHCN) that provides leadership in the enhancement of specialty medical services; care coordination; medical insurance benefits evaluation and coordination; management of the CSHCN Pool of Funds: information and referral to CSHCN resources; family-to-family support; and training and consultation with community providers on CSHCN issues. The centers are geographically located to serve the entire state. Virginia resident children ages birth to 21 years are eligible for services if their disorder has a physical basis; has lasted or is expected to last for at least 12 months; and either requires health care and ancillary services over and above the usual for the child's age, or special ongoing treatments, interventions, or accommodation at home or school, or limits function in comparison to healthy age children; or is dependent on medications, special diet, medical technology, assistive devices or personal assistance. A limited amount of money (CSHCN Pool of Funds) is available to assist children who are uninsured or underinsured. This assistance is limited to families with a gross income at or below 300% of the Federal Poverty Level.

The Child Development Clinics, also managed by the Division of Child and Adolescent Health, is a specialized program for children and adolescents suspected of having developmental and behavioral disorders such as developmental delays, disorders of attention and hyperactivity,

learning problems, mental retardation, and/or emotional and behavioral concerns. A professional team consisting of a pediatrician or nurse practitioner, nurse, social worker, educational consultant, and psychologist provide diagnostic assessment, treatment planning, follow-up care coordination and referral. Interagency coordination is provided with the Virginia Department of Education, local health departments, Part C early intervention services, mental health clinics, Head Start programs, Department of Social Services and others. Eligibility is limited to Virginia resident children under the age of 21 years. A sliding scale charge is based on income level and family size.

The Virginia Bleeding Disorders Program, a legislatively enacted program, was established to serve as a "safety net" for persons with inherited bleeding disorders. The Virginia Bleeding Disorders Program provides insurance case management that assists persons in considering their options and completing the insurance application and enrollment process. The program provides assistance in accessing specialty health care services and establishing a medical home, care coordination, information and referral, family-to-family support, training and technical assistance for community providers, transition from child to adult oriented health care system, and the promotion of quality assurance. A limited amount of money is also available to assist uninsured and underinsured persons to receive care that they would otherwise not be able to afford. Bleeding disorder centers are located in Norfolk, Fairfax, Richmond and Charlottesville. The Virginia Hemophilia Advisory Board, consisting of governor appointed members, provides a mechanism to address the statewide needs of persons with inherited bleeding disorders.

The Division of Dental Health's primary goal is to prevent dental disease. Karen Day, D.D.S., M.P.H., is the division director. Dental services are provided in approximately half of Virginia's localities to pre-school and school age children who meet eligibility requirements through the local health departments. Eligibility for these services may be determined by school lunch status and/or family income. Dental services are available at health department clinics or at dental trailers placed on school property. Adult care is available on a limited basis in certain localities. The Division of Dental Health also supports community fluoridation by monitoring water systems for compliance in conjunction with Virginia Department of Health Office of Drinking Water, reporting water system data to the Centers for Disease Control and Prevention Water Fluoridation Reporting System (WFRS), providing information about the benefits of water fluoridation to citizens and communities, and by providing grant funding for communities to start or upgrade fluoridation equipment. The division also engages in epidemiological studies to determine the level of need for dental care. Most recently 8,000 school children were surveyed to document the level of decay, fillings, missing teeth and dental sealants.

In the past the Division of Dental Health supported the School Fluoride Mouthrinse Program and provided funding for fluoride mouthrinse supplies, training on implementing school mouthrinse programs, and brochures and educational information regarding the program. This program was eliminated this year as a result of budget reductions. The division's "Bright Smiles for Babies" Program targets children from birth to three years old at highest risk for dental decay. The goal of the program is to increase early recognition of disease and provide prevention through training dental and non-dental health professionals on oral health education and anticipatory guidance, screening and risk assessment and fluoride varnish application. The division recently expanded the Bright Smiles for Babies program to provide training, presentations, educational materials and resources for parents/caregivers and providers regarding oral health for children with special health care needs. In the past it has been difficult for parents to find dentists who provide care to CSHCN. The Division of Dental Health surveyed Virginia's dentist in order to develop a provider directory. As a result of the responses received from the dentists, an interactive provider directory is now available to families of CSHCN on the VDH website. http://www.vahealth.org/dental/dentaldirectory/QuickSearch.aspx

Funding for both the Dental Scholarship Program and the Dental Loan Repayment Program that provides funding for dental students with repayment through service in underserved areas was recently eliminated due to the economic turndown that has resulted in state budget reductions.

The Director of the Division of Nutrition, Physical Activity and Food Programs (formerly the Division of WIC and Community Nutrition Services) is Donna Seward, F.A.C.H.E. The division administers the Virginia Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) serving approximately 160,000 low to moderate income families through local health departments and mobile clinics. The WIC program goal is to enable women to deliver and nurture healthy children. The WIC program includes outreach and education components and encourages breastfeeding for new mothers. Effective October 1, 2010, the division will take over the administration of two additional food programs, the Child and Adult Care Food Program and the Summer Food Service Program. The division implemented CHAMPION, the Commonwealth's Health Approach and Mobilization Plan for Inactivity, Obesity, and Nutrition to address the increase in obesity rates statewide. The program uses a community driven approach by providing communities with evidence based program models, technical assistance and limited grant funds to implement the community initiative. Grants are available statewide and include funding for programs and strategies that target health behavior, policy, and environmental change. Specifically, funding is provided for programs to address nutrition education, physical activity, and policy change in preschool settings, for parents of adolescents, to create active aging environments, promote worksite wellness, and support breastfeeding promotion.

The Statewide Breastfeeding Advisory Committee is comprised of stakeholders representing various organizations. The member organizations represent a wide variety of practice settings and create a multidisciplinary membership. They work in partnership with the Virginia Department of Health's Division of Women's and Infants' Health and the Division of Nutrition, Physical Activity, and Food Programs to aid in increasing the incidence and duration of breastfeeding among mothers. Representatives include such organizations as the American College of Nurse Midwives, the American Dietetic Association, universities, La Leche League, Medela, the Virginia Nurses Association and others.

The Division of Injury and Violence Prevention's primary goal is to prevent injuries, suicide and violence. Erima Fobbs, B.Sc., M.P.H. is the director. To reduce the impact of injury and violence, the division engages in injury assessment, the development and promotion of prevention programs and policies, training and community education. The division also promotes and disseminates safety devices, conducts public information campaigns and funds local prevention projects. The division works collaboratively with health, education, social service and mental health providers, law enforcement, fire and EMS providers, and a variety of other community groups across the Commonwealth. The division's unintentional injury programs address home, school and transportation safety including child passenger safety, infant safety, traumatic brain injury, fire and drowning prevention. The division's violence prevention programs address sexual violence, suicide, youth violence, including bullying, and intimate partner violence.

The goal of the Chronic Disease Prevention and Control Division is to reduce the human and financial burden of chronic diseases, which are the leading causes of death in Virginia. The division director is Ramona Schaeffer, M.S.Ed, C.H.E.S. The division's prevention and control efforts include the development of programs and policies, training and state action plans that outline goals and strategies for business, civic and governmental agencies to control chronic diseases such as arthritis, asthma, cancer, diabetes, or heart disease and stroke. The division focuses on promoting evidence-based interventions, monitoring the burden of chronic diseases in the state, developing partnerships with other state and local agencies, and evaluating outcomes of projects interventions. Other division efforts include outreach to promote health for persons living with disabilities and prevention of secondary chronic diseases, and to modify risk behaviors such as tobacco use, lack of physical activity and poor nutrition, which are major contributing factors leading to chronic diseases. The division manages numerous categorical CDC grants including the CDC funded Tobacco Use Control Program (TUCP). In addition, the Virginia Cancer Registry is located within this division.

The Office of Family Health Services is responsible for addressing several federal (e.g., Title V

and Title X) and state mandates for improving the health of women and children. State statutes relevant to Virginia's Title V program authority are included in the attachment to this section.

Culturally Competent Care
The OFHS is committed to providing culturally competent care for the MCH populations. This is being accomplished in a number of ways. First, data is collected and analyzed according to different race and ethnic categories and used to inform program development including the targeting of resources. The race and ethnic categories have been standardized across data collection systems that are housed in the OFHS DataMart. OFHS also collaborates with culturally diverse community groups to ensure their representation in needs assessment, program planning and evaluation. For example, findings from five minority focus groups were utilized in the development of web-based training for providers on identifying and addressing perinatal depression. Efforts are made to ensure that health promotion materials are culturally appropriate and translated into appropriate languages, with Spanish being the most prevalent. News releases regarding public health issues are placed in newspapers that are read in different racial and ethnic communities. OFHS staff participate in cultural competency trainings. For example, the Care Connection for Children staff participated in two days of training on cultural competency provided by the Georgetown University Center for Cultural competency. A recent in-service training on racial disparities sponsored by the Office of Minority Health and Health Equity was attended by a number of Title V staff. Contracts with the district health departments for maternal and child health services include a requirement that care must be provided in a culturally competent manner. To assure a representative OFHS workforce, position vacancies are posted in newspapers and on websites that are viewed by different racial and ethnic communities.

VDH contracts with Language Services Associates (LSA) for telephone interpreting and document translating. LSA offers interpreting and translating services in 212 languages, including all of the 50+ languages specifically required by VDH in their Request for Proposals. The Virginia Department of Health's Office of Minority Health and Health Equity developed a website that provides resources to assist health care providers to better meet the needs of the Commonwealth's diverse populations. The resources include training materials, research articles, assessment tools and a calendar of events. The website also provides language resources that include a list of commonly used clinical phrases in both English and Spanish. OHFS continues to work with the OHP to develop additional resources that specifically target the diverse MCH population. The website is available at http://clasactVirginia.vdh.virginia.gov.

In 1990, Virginia's State Health Commissioner created the Minority Health Advisory Committee (MHAC) to ensure that the health priorities and health concerns of Virginia's minority populations were adequately addressed by the Virginia Department of Health. The MHAC includes appointed representatives from local, state and federal public health agencies, University of Virginia's Center for Public Service, Virginia Commonwealth University's Department of Pharmaceuticals, Norfolk State University's Department of Political Science and Economics, Baptist General Convention of Virginia, Vietnamese Resettlement Association, Powhatan Society, Hispanic Committee of Virginia, private health care providers and consumers. MHAC's membership is intended to be representative of Virginia's minority and underserved populations. Their work includes advising and making recommendations to the VDH Commissioner, identifying limitations associated with existing laws, regulations, programs and services, identifying and reviewing health promotion and disease prevention strategies and supporting policies and legislation to improve accessibility and acceptability of health services.

Legislation requested by former Governor Kaine and adopted by the 2007 General Assembly gives greater emphasis on minority health issues by directing the State Health Commissioner to designate a senior staff member who is a licensed physician to direct the Department's minority health efforts. Michael Royster, M.D., M.P.H. has been appointed to this position and serves as the Director of Minority Health and Public Health Policy for the Department of Health.

/2012/ During the past year, the OFHS has been going through reorganization in order to

combine functions and increase collaboration, efficiency and effectiveness. The new Division of Child and Family Health was created by combining the programs within the previous divisions of Dental Health, Women's and Infants' Health and Child and Adolescent Health. The previous division directors are currently program managers in their respective areas. Nancy Ford, B.S.N., M.P.H., is the Director of the new Child and Family Health Division. She has approximately 31 years of public health experience and previously served as the Director of Pediatric Screening and Genetic Services in the Division of Child and Adolescent Health.

The Division of Chronic Disease Prevention and Control and the Division of Injury and Violence Prevention were combined to create the new Division of Prevention and Health Promotion. Erima Fobbs, B.Sc., M.P.H., formerly the director of the Division of Injury and Violence Prevention is the director of the new division. Ramona Schaeffer, the former director of the Division of Chronic Disease Prevention and Control, remains as the chronic disease program manager.

Michael Welch, Ph.D. is the current director of the Division of Nutrition, Physical Activity and Food Programs following the retirement of Donna Seward. He has approximately 14 years of public health experience including his previous position as the Community Health Programs Manager (WIC, Lead Free Richmond, Dental and Chronic Disease) at the Richmond City Health Department.

The OFHS business unit is also undergoing some changes. Mr. Claiborne Watkins was recently appointed as the Deputy for Administration. Mr. Watkins previously served as the Director of Policy, Analysis, Procurement and Support Services for the Virginia Department of Alcoholic Beverage Control.

Future reorganization plans include the addition of a Policy and Evaluation Division. The division will consolidate the epidemiologists and the policy analysts in order to increase the standardization of data analysis and reporting, strengthen evaluation activities and increase the use of data in planning and decision making. //2012//

/2013/ During the past year, the OFHS completed its reorganization with the goals to combine and enhance functions and to increase collaboration, efficiency, and effectiveness. The current OFHS Director, Diane Helentjaris, M.D., M.P.H. is resigning and recruitment is underway for the new Director.

The Division of Child and Family Health is now comprised of Child Health, Reproductive Health, and Dental Health units. Nancy Ford, B.S.N., M.P.H., served as the director of this newly created division until her retirement in March 2012. Cornelia Ramsey, Ph.D., is the new director of this division effective May 25, 2012. The majority of programs in the former previous Divisions of Dental Health, Women's and Infants' Health and Child and Adolescent Health remained in the new division. However, the Every Woman's Life and WISEWOMAN programs are now included in the Division of Prevention and Health Promotion. Some additional program placement changes have been made within this new division. The sickle cell program was moved to the Child Health unit to be organizationally with the other Children with Special Health Care Needs programs. The Teen Pregnancy Prevention Initiative remains in the newly established Division of Child and Family Health, but has been relocated to the Reproductive Health unit of the division. The 2013-2014 state budget eliminates funding for this program. These programs will be transitioned under the abstinence program. Within the Reproductive Health unit, several new grant initiatives have resulted in increased capacity to work on expanded home visiting, abstinence, first-time motherhood, and pregnancy assistance fund for college students. In addition, state budget language requiring VDH to help increase enrollment in Plan First, the state Medicaid family planning waiver has also resulted in an additional staff person.

The Children with Special Health Care Needs Program remains within the Child Health unit. Nancy Bullock, the CSHCN director retired effective October 1, 2011. Sidnee' Dallas, M.Div.,

M.P.H., formerly with the VDH newcomer health program, started as the new CSHCN director in February 2012. While the program capacity and operations remains as described, the 2012 Virginia General Assembly eliminated a number of boards and advisory committees as a result of the Governor's Executive branch reorganization plan. The Virginia Hemophilia Advisory Board was eliminated with the requirement that the Virginia Board of Health continue to assure the development, implementation, and sustainability of a process for the receipt and consideration of advice and policy recommendations from, and on behalf of, persons suffering from hemophilia and other related bleeding diseases.

Dental health capacity in Virginia will be experiencing changes in service delivery. The 2012 Virginia General Assembly expanded the authority for remote dental supervision of dental hygienists from three pilot health districts to statewide. In addition, the state budget for 2013-2014 calls for transitioning local health department dental services to a completely preventive model. The previous Dental Health unit and former Division of Dental Health director, Dr. Karen Day retired effective March 1, 2012. Recruitment for the dental program manager is currently underway.

The new Division of Prevention and Health Promotion continues to be led by Erima Fobbs, M.P.H. and is comprised of three units: Chronic Disease Prevention and Control; Health Promotion; and Injury and Violence Prevention. In addition to taking on the Every Woman's Life and WISEWOMAN programs, VDH obesity and physical activity initiatives have been relocated to this division under the Health Promotion unit. Previously these initiatives were under the formerly named Division of Nutrition, Physical Activity, and Food Programs.

The Division of Nutrition and Food Programs, renamed to reflect the movement of obesity and physical activity programs, continues to be led by Michael Welch.

A new Division of Policy and Evaluation has been created to provide leadership in data analysis, evaluation, and policy development in support of all OFHS programs. This new Division has five units: Education and Outreach; Epidemiology; Program Evaluation; Surveys and Analyses; and the Virginia Cancer Registry. Dev Nair, Ph.D., M.P.H., started as Director in February 2012. The Division incorporated functions of the previous Policy and Assessment Unit as well as some new areas. Janice Hicks who led this unit retired in September 2011. The newly formed Education and Outreach unit will expand OFHS capacity to provide more broad support and increase ability to provide culturally competent services. This unit has two new positions; one to specifically address special populations and one to provide outreach to Hispanic populations. This will help address the growing needs in light of changing demographics of Virginia's maternal and child health population to deliver more effective services. The Epidemiology unit combines staff previously in other divisions to provide more efficient data analyses for the office. The Program Evaluation unit will provide comprehensive evaluations of all programs on a cyclical schedule and include both grant required evaluation as well as broader and
more systematic study of programs as they relate to cost/benefit; policy compliance; and other metrics. Surveys and Analyses contains the major public health surveys (BRFSS, PRAMS, YRBS) as well as provides legislative, policy analysis, and Institutional Review Board support. The Virginia Cancer Registry was moved into this division from the former Division of Chronic Disease Prevention and Control. //2013//

/2014/ During the past year, Lauri Kalanges, M.D., M.P.H., was appointed as the Deputy Director of the Office of Family Health Services effective December 2012. She has also been serving as the Acting Director of the Office of Family Health Services since February 2013. In the Division of Prevention and Health Promotion, Erima Fobbs is no longer serving as the Division Director as of April 2013 and Dr. Kalanges is currently serving as the Acting Director while recruitment is underway for a new Division Director. In the Division of Child and Family Health, Tonya McRae Adiches, R.D.H., was selected as the Dental Health program manager effective October 2012. The Division of Policy and Evaluation has also expanded with the addition of Shahid Hafidh, M.P.H., as the Program Evaluation Manager in October 2012 and Brendan Noggle, M.P.H., as

the Epidemiology Manager in February 2013. //2014//

/2015/ Lauri Kalanges, M.D., M.P.H., served as the Acting OFHS Director until December, 2013. Dev Nair, Ph.D., M.P.H. served as the Acting Director of the Office of Family Health Services from December, 2013 to April 9, 2013. Lilian Peake, M.D., M.P.H., became the Director of the Office of Family Health Services on April 10, 2014. Dr. Peake is the former director of the Thomas Jefferson District Health Department.

Dr. Kalanges was recently elected to serve as the Region III representative on the AMCHP Board.

Emily McClellan accepted the position of the Division of Policy and Evaluation's Survey and Analyses Manager in September 2013. She replaces the former manager, Susan Tlusty, who resigned.

Letha Fisher is currently the Director of the Division of Prevention and Health Promotion.

Joanne Boise, Child Health Programs Manager in the Division of Child and Family Health, resigned in April, 2014.

Stephen Vecchionne is currently the OFHS Administrative Deputy, a position previously held by Clai Watkins.
//2015//

An attachment is included in this section. IIIB - Agency Capacity

C. Organizational Structure

The Virginia Title V program is housed within the Virginia Department of Health, one of twelve agencies within the
cabinet level Health and Human Resources Secretariat. In January 2010, the newly elected Governor, Bob McDonnell, appointed Bill Hazel, M.D. as the Secretary of Health and Human Resources. Dr. Hazel is involved with numerous healthcare related associations and is a board certified orthopedic surgeon. Karen Remley, M.D., M.B.A., F.A.A.P., appointed by the previous governor Tim Kaine, has been reappointed as the State Health Commissioner. The Virginia Department of Health includes four deputy commissioners who provide oversight for Community Health Services; Public Health and Preparedness; Public Health; and Administration.

The Virginia Department of Health (VDH) is mandated by the Code of Virginia to "administer and provide a
comprehensive program of preventive, curative, restorative and environmental health services, educate the citizenry in health and environmental matters, develop and implement health resource plans, collect and preserve vital records and health statistics, assist in research, and abate hazards and nuisances to the health and environment, both emergency and otherwise, thereby improving the quality of life in the Commonwealth." In carrying out these responsibilities, VDH, in conjunction with the Board of Health, promulgates and enforces over 60 sets of regulations and manages over 70 federal and state grants.

In 1947, the Virginia General Assembly passed legislation requiring "each county and city to establish and maintain a local health department." Then in 1954, the Virginia General Assembly passed legislation that permitted the Department to organize the local health departments into 35 health districts which now include 119 local health departments. The local health departments are jointly funded by the state and the cities and counties that they serve. The local funding is based on the ability to pay with some localities contributing as little as 18% while others contribute as much as 45% match to state dollars. Each health district has a cooperative agreement that delineates the mandated basic health services that each district must provide and

any additional services based on need and available funds. The General Assembly has authorized the local governments in Arlington and Fairfax to manage their own health departments and they operate under a contractual agreement with the state.

Section 32.1-77 of the Code of Virginia specifically addresses VDH's authorization to prepare and submit to the U.S. Department of Health and Human Services the state Title V plan for maternal and child health services and services for children with special health care needs. The Commissioner of Health is authorized to administer the plan and expend the Title V funds.

Within VDH's central office, the Title V Block Grant is managed by the Office of Family Health Services (OFHS). David Suttle, M.D., the OFHS director and also the Title V director retired on April 30, 2010 and Diane Helentjaris, M.D., M.P.H. was appointed as OFHS director on May 25, 2010. Dr. Helentjaris reports directly to the Chief Deputy Commissioner for Public Health. Other offices under the direction of the Deputy for Public Health include Drinking Water, Epidemiology and Environmental Health.

/2012/ Maureen Dempsey, M.D., F.A.A.P., was appointed as the Chief Deputy Commissioner for Public Health in
November, 2010. //2012//

/2014/ Maureen Dempsey, M.D., F.A.A.P., resigned in January 2013. Marissa Levine, M.D., M.P.H., was selected as the Chief Deputy Commissioner for Public Health in June 2013 after having served in that role on an acting basis since February 2013. In this role Dr. Levine continues her oversight of the offices under the purview of the Deputy Commissioner for Public Health and Preparedness in addition to those overseen by the Chief Deputy. //2014//

/2014/ Karen Remley, M.D., M.B.A., F.A.A.P., resigned as State Health Commissioner in October 2012. Cynthia C.
Romero, M.D., F.A.A.F.P. was appointed as State Health Commissioner effective January 2013. //2014//

/2015/ In January 2014, Terence McAuliffe became Governor of Virginia. Governor McAuliffe reappointed Bill Hazel, M.D. as the Secretary of Health and Human Resources. In addition, Governor McAuliffe appointed Marissa Levine, M.D., M.P.H., F.A.A.P., formerly the acting Health Commissioner, as Health Commissioner following the resignation of State Health Commissioner Cynthia Romero, M.D. //2015//

/2015/ Over the past few months, the Office of the State Health Commissioner has experienced changes in the deputy commissioners' assignments and oversight. The most significant change for the Office of Family Health Services is that the office now reports to the Deputy of Community Health Services, Robert Hicks. Previously, OFHS reported to the Deputy Commissioner for Public Health Programs. The placement of OFHS under this deputy recognizes the important relationship that OFHS has with the district health departments and other community organizations in providing services at the local level. //2015//

The administration of the Block Grant resides at the OFHS office level while divisions within the Office have specific responsibility for carrying out MCH programs. The divisions include Dental Health, Women's and Infants' Health, Chronic Disease Prevention and Control, Child and Adolescent Health, Nutrition, Physical Activity and Food Programs and Injury and Violence Prevention. The CSHCN program resides within the Office's Division of Child and Adolescent Health.

The mission of the OFHS is to provide the leadership, expertise and resources that enable all Virginia residents to reach and maintain their optimum level of health and well-being throughout life. In order to accomplish this, the office is organized into the Director's office and six divisions.

The Director's office includes crosscutting functions which are comprised of the Business Unit and the Policy and Assessment Unit. The Business Unit includes budgeting, accounting, contracting, grants management, procurement and human resource functions. The Policy and Assessment Unit (PAU) mission is to assure that valid, reliable, and timely health information is available to direct effective policies and actions. More specifically the PAU provides leadership in the development and management of the Title V and the Preventive Health and Health Services (PHHS) block grants; manages special information technology projects; coordinates the legislative review process; manages the Behavior Risk Factor Surveillance System Survey (BRFSS), the Pregnancy Risk Assessment Monitoring System (PRAMS) and the Virginia Youth Survey (VYS), the Virginia Assessment Initiative (VAIP) and the State Systems Development Initiative (SSDI); creates and maintains a standard electronic repository of OFHS health-related data including linked datasets; develops and provides web-based tools to disseminate health information for community health assessments; and provides training and consultation to OFHS staff regarding epidemiologic practices, statistical analysis and program evaluation.

/2012/ See Agency Capacity section for detailed information on the OFHS reorganization. //2012//

Title V funds are provided annually to the 35 health districts to support maternal and child health services. The district funding levels are based on an estimate of the proportion of low income (200% FPL) births within each of the districts. A total of approximately $3.5 million is annually provided to the districts. Currently district Title V funding addresses the following areas: perinatal services, dental services, injury prevention, obesity prevention, infant mortality, breastfeeding, teen pregnancy prevention, child care safety, and access to care.

Organizational charts for the Virginia Department of Health and the Office of Family Health Services are attached.
/2013/ Diane Helentjaris, M.D., M.P.H, the current OFHS Director is resigning and recruitment for the new Director is underway. Details regarding the completed OFHS reorganization are in the Agency Capacity section. //2013//

/2014/ Lauri Kalanges, M.D., M.P.H., was selected as the OFHS Deputy Director in December 2012. As of February 2013, Dr. Kalanges has also been serving as the Acting OFHS Director. //2014//

/2015/ Lauri Kalanges, M.D., M.P.H., served as the Acting OFHS Director until December, 2013. Dev Nair, Ph.D., Director of the Division of Policy and Evaluation, served as the Acting OFHS Director between December, 2013 and April 9, 2014. Liian Peake, M.D., M.P.H. became the OFHS Director on April 10, 2014. Dr. Peake is the former director of the Thomas Jefferson Health District //2015//

An attachment is included in this section. IIIC - Organizational Structure

D. Other MCH Capacity

Virginia's MCH Program, comprised of staff in the Office of Family Health Services, includes a highly skilled and diverse team of public health professionals representing a variety of disciplines. In addition, numerous district health department staff, including physicians, public health nurses, and support staff are also supported in part by Title V funds.

Senior level MCH staff in the Office of Family Health Services include the following:

Diane Helentjaris, M.D., M.P.H. was appointed as the Director of the Office of Family Health Services effective May 25, 2010 following the retirement of David Suttle, MD. Dr. Helentjaris previously served as the director of the Loudoun Health District and the Lord Fairfax Health District, the Richmond City Health Department's deputy director, director for the H1N1 Response,

the Deputy State Epidemiologist, and Deputy Director of the Office of Epidemiology. She also serves as an affiliate faculty member in the Virginia Commonwealth University's Department of Epidemiology and Community Health.

/2013/ Dr. Helentjaris is resigning her position. Recruitment for the OFHS Director is currently underway. //2013//

/2014/ Lauri Kalanges, M.D., M.P.H. was appointed as the Deputy Director of the Office of Family Health Services effective December 2012. Dr. Kalanges has over 20 years of experience in leadership positions in various health organizations, including over five years as a senior leader in Texas where she served as the Texas Chronic Disease Section Medical Director. She also served as Medical Director for the Breast and Cervical Cancer, Maternal/Child Health, Primary Care, Reproductive Health and Quality Improvement programs in Texas. Dr. Kalanges has also been serving as the Acting Director of the Office of Family Health Services since February 2013. In this role, she also serves as the Virginia Title V MCH Director and was selected to participate in the 18 month AMCHP Title V New Director Mentor Program. //2014//

Janice M. Hicks, Ph.D. has served as the Policy and Assessment Director since 1997 and as the Office of Family Health Services' Senior Policy Analyst since 1994. She has over 20 years of experience in planning, evaluation and legislative analysis. Dr. Hicks also has experience in teaching college level courses in Sociology, Research Methods, Evaluation, Social Theory, Family, and Criminology/Juvenile Delinquency. She also serves as an adjunct faculty member in the Virginia Commonwealth University's Department of Epidemiology and Community Health.

/2013/ Dr. Hicks retired in September 2011. //2013//

/2014/ Following her retirement, Dr. Hicks returned to the Office of Family Health Services on a part time basis in 2012. //2014//

The Policy and Assessment Unit includes the grants coordinator (Robin Buskey), the State Systems Development Initiative (SSDI) Coordinator (Caroline Stampfel), the MCH Epidemiologist (Derek Chapman, PhD.), the Behavioral Risk Factor Surveillance System Coordinator (Susan Spain), a Senior Health Policy Analyst (Kim Barnes) who continues to serve as the agency HIPAA compliance officer, the OFHS liaison to the Department of Medical Assistance Services on issues involving Medicaid and FAMIS and participates in special projects that include business intelligence applications, emergency preparedness and health information exchange. Marilyn Wenner serves as the PRAMS Coordinator, Shanee Harmon serves as the Virginia Youth Survey Coordinator (YRBS) and Michelle White is the Virginia Assessment Initiative Coordinator.

/2012/ Caroline Stampfel resigned in March 2011 to take a position as Senior Epidemiologist at the Association of Maternal and Child Health Programs (AMCHP). Kim Barnes was transferred to the Office of Information Management and is currently working on the health information exchange project. She continues to serve as the agency HIPPA compliance officer. //2012//

/2013/ Following Ms. Stampfel's resignation, Kristin Austin, formerly the PRAMS data analyst, accepted the position; the MCH Epidemiologist, and SSDI Coordinator. Ms. Austin resigned in the fall to accept a position at Virginia Commonwealth University. Christopher Hill is currently serving as the MCH Epidemiologist. He was previously the MCH Epidemiologist in the Wyoming Health Department. Both Robin Buskey and Michelle White resigned in 2011. Susan Spain resigned effective March 1, 2012. Shanee Harmon has taken over the role of the Behavioral Risk Factor Surveillance System Coordinator.

As a result of the reorganization, the Division of Policy and Evaluation was established. Dev Nair, Ph.D., M.P.H. is the new director. He is president-elect of the Virginia Public Health Association and a prior Director of Clinical Review Services at Virginia Health Quality Center (the federally designated quality improvement organization for the Commonwealth). He previously served as a

deputy Medicaid director in Georgia. In this role he was responsible for clinical and quality operations with a primary focus on improving the health care of Medicaid recipients.

The Division of Policy and Evaluation includes the staff from the Policy and Assessment Unit and the Cancer Registry and consolidates the office epidemiology and evaluation functions as well as training. Efforts are continuing to fill a number of division vacancies resulting from resignations as well as new positions established in the division. //2013//

/2014/ Shanee Harmon, Behavioral Risk Factor Surveillance System (BRFSS) Coordinator, resigned in the fall. Danielle Henderson joined the Division of Policy and Evaluation as the Public Health Surveys Coordinator for the Virginia BRFSS and Virginia Youth Survey (VYS) as of November 19, 2012. Marilyn Wenner, PRAMS Coordinator, resigned in March 2013. Chris Hill is currently serving as the PRAMS Coordinator while the recruitment process continues. The Division recruited for and hired two management positions; Shahid Hafidh, M.P.H., was selected as the Program Evaluation Manager in October 2012 and Brendan Noggle, M.P.H., was selected as the Epidemiology Manager in February 2013. //2014//

Karen Day, D.D.S., M.S., M.P.H., has served in her current capacity as Director of the Division of Dental Health with the Virginia Department of Health (VDH) since 1996. Prior to this position she served as Community Water Fluoridation Coordinator for the Division for three years and as a public health dentist for fifteen years. Dr. Day has taught graduate and undergraduate courses at Virginia Commonwealth University including biology, oral epidemiology, principals of public health and public health dentistry.

/2015/ Dr. Day recently returned to the OFHS, Dental Health Program, to manage a CDC dental health grant. //2015//

/2012/ The Dental Health program is now a part of the new Division of Child and Family Health. Dr. Day is currently the Dental Health program manager. //2012//

/2013/ Dr. Day retired in March 2012. Recruitment is underway for the Dental Health program manager position.
//2013//

/2014/ Tonya McRae Adiches, R.D.H., was selected as the Dental Health program manager effective October 2012. Prior to accepting this position, she served as the Oral Health Workforce Coordinator and as the Adult Oral Health Program Coordinator with the Division of Dental Health.//2014//

Nancy R. Bullock, R.N., M.P.H., the CSHCN Program Director, has over 40 years of experience in public health in Virginia. She served as a nurse consultant, program and division director at the state level and at the local level as a public health nurse and nurse manager. She has been the director of the CSHCN Program since 1991.

/2013/ Nancy Bullock, the CSHCN director retired effective October 1, 2011. Sidnee' Dallas, M. Div., M.P.H., formerly with the VDH newcomer health program, started as the new CSHCN director in February 2012. //2013//

/2014/ Sidnee' Dallas, M. Div., M.P.H., was selected to participate in the 18 month AMCHP Title V New Director Mentor Program along with Dr. Lauri Kalanges. //2014//

Joan Corder-Mabe, R.N.C., M.S., W.H.N.P., was selected as the Director for the Division of Women's and Infants' Health in 2001. Previously she served as the perinatal nurse consultant and the Acting Division Director. She is responsible for programs including the Title X Family Planning, the Virginia Healthy Start Initiative, the CDC Breast and Cervical Cancer Early Detection Program, Partners in Prevention, the Resource Mothers Program, Women's Health, the

Regional Perinatal Councils, and the Comprehensive Sickle Cell Program. She and the division staff also provide consultation and technical assistance to the local health departments serving perinatal clients.

/2012/ The Women's and Infants' Health program is now a part of the new Division of Child and Family Health. Ms. Corder-Mabe is currently the Women's and Infants' Health program manager. //2012//

Joanne S. Boise has served as Director of the Division of Child and Adolescent Health since June 2001. With a background in nursing, she holds an M.S.P.H. in health policy and administration. Prior to joining VDH, Ms. Boise spent fifteen years in the managed care industry working locally and nationally; she has held positions in health policy, HMO operations, quality improvement, utilization management, and network management. She oversees the VDH newborn screening programs, CSHCN programs, early and school age childhood initiatives, and teen pregnancy prevention. She co-leads the Bright Futures Virginia effort and works closely with the Virginia Chapter of the American Academy of Pediatrics on a number of projects to improve well-child care. She was a member of Virginia's Core Team for the ABCD Screening Academy and continues to champion the medical home, routine developmental screening as part of well child care, and prompt referral to early intervention.

/2012/ The Child and Adolescent Health program is now a part of the new Division of Child and Family Health. Ms. Boise is currently the Child and Adolescent Health program manager. //2012//

/2013/ Nancy Ford served as the Director of the Division of Child and Family Health until her retirement in March 2012. Cornelia Ramsey, Ph.D., is the new division director effective May 25, 2012. //2013//

Donna Seward, B.S., has served in her current capacity as the Director of the Nutrition, Physical Activity and Food Programs (formerly the Division of WIC and Community Nutrition Services) since April 2000. She is responsible for the management of Virginia's WIC program and two new food programs -- the Child and Adult Care Food Program and the Summer Food Service Program. She also has responsibility for CHAMPION, the obesity prevention initiative. From 1976 to 2000 she served as the WIC Director at the local level in Texas. Her educational background is in health care management.

/2012/ Following Donna Seward's resignation, Michael Welch was appointed as the Division Director. //2012//

Erima S. Fobbs, B.Sc., M.P.H., is the Director of the Division of Injury and Violence Prevention (DIVP). Her MPH included a concentration on Epidemiology and Health Services Administration. She has over 22 years of experience in prevention and has directed Virginia's statewide injury and violence prevention program since 1994. She has also taught courses on the Epidemiology and Prevention of Intentional Injury as an adjunct assistant professor at MCV/VCU department of Preventive Medicine and Public Health and is a certified suicide prevention and bullying prevention program trainer.

/2012/ Erima Fobbs is currently serving as the Director of the new Prevention and Health Promotion Division. //2012//

/2014/ Erima Fobbs is no longer employed by VDH effective April 2013. Dr. Lauri Kalanges is currently serving as the Acting Director of the Division of Prevention and Health Promotion. //2014//

/2015/ Letha Fisher was named as the new director of the Division of Prevention and Health Promotion. //2015//

In the fall of 2004, OFHS contracted with the Virginia Commonwealth University's Public Health program to hire a faculty level MCH epidemiologist. Derek Chapman, Ph.D. was hired in this jointly appointed position that is supported in part by SSDI funds. Dr. Chapman previously served as the Director of Research at the Tennessee Department of Health and has a number of years of experience working with MCH data. The joint appointment of Dr. Chapman provides an opportunity for greater collaboration between the OFHS and the VCU Public Health program and has resulted in benefits for both OFHS and the University through increased opportunities for grants, student internships, technical assistance and publications. Dr. Chapman works closely with the division level epidemiologists to establish greater access to data including the development of the OFHS Data Mart, a repository of data selected and organized to support the surveillance and evaluation needs of the OFHS epidemiologists. The Data Mart consists of key datasets that are cleaned, aggregated, and standardized to enable automation of regular ongoing surveillance reporting and analysis. The data are used by all divisions for surveillance, assessment, program planning, grant applications, and grant reporting.

The OFHS Policy and Assessment Unit has taken advantage of the Council of State and Territorial Epidemiologists' (CSTE) 2-year fellowship program. Caroline Stampfel, the first CSTE fellow placed in the OFHS, was hired as an OFHS MCH epidemiologist following her fellowship. The second fellow, Andrea Alvarez, completed her CSTE fellowship and was hired by the VDH Office of Epidemiology. A third CSTE fellow will join the Policy and Assessment Unit in August 2010 for a 2-year fellowship.

/2012/ Gandarvaka Gray, a CSTE fellow, joined the Policy and Assessment Unit in August 2010. //2012//

/2013/ Gandarvaka Gray's CSTE fellowship will end in August 2012. She has been accepted into the UNC-Chapel Hill public health doctoral program. //2013//

/2014/ Latoya Hill will be joining the Division of Policy and Evaluation as the fourth CSTE fellow placed in the Office of Family Health Services. She will begin her two year fellowship in August 2013. //2014//

The OFHS Policy and Assessment Unit has also hosted a number of MCHB Graduate Student Internship Program (GSIP) students over the years. Currently, a graduate student from the University of North Carolina is serving as a GSIP intern for the summer.

/2011/ Two new GSIP students will work with Policy and Assessment staff this summer. One will be working on PRAMS fact sheets while the other will be working on identifying state performance measures for the Title V Priority #8 - optimal child development. //2012//

In order to continue to increase our capacity and to better use our available resources, the Policy and Assessment Unit has created a team to review all research and evaluation proposals. The review team, made up of Policy and Assessment staff as well as research-related representatives from the Divisions, work closely with Division staff to review plans for research and evaluation activities to be completed in-house or through a contractor.

The benefits of this new review process include:

A decrease in the duplication of research and evaluation activities that occur across the OFHS divisions;
An increase in the amount of funding available for program activities and a decrease in the amount of funding spent on
research and evaluation activities;
An increase in the research and evaluation capacity of OFHS program staff;
An increase in collaboration across the OFHS divisions;

An increase in the identification of qualified contractors;
An increase in OFHS staff support in developing their research activities; and
An increase in oversight of all research and evaluation activities to ensure that work that is contracted out is reasonable,
cost-effective, and necessary.

/2012/ Beginning this year, the OFHS will manage and staff the agency Institutional Review Board (IRB). //2012//

/2013/ A new Coordinator for the State Child Fatality Review Team, Emily Gambill, was hired in July 2011. Ms. Gambill is participating in relevant workgroups and statewide committees including representing Virginia's child fatality review efforts on the regionally based Southeastern Coalition on Child Fatalities. //2013//

Family Involvement

OFHS provides a number of opportunities for family input into the MCH and CSHCN programs. A parent feedback survey is used to assess the services provided by Care Connection for Children centers, Bleeding Disorders Program, and the Child Development Clinics. The Care Connection for Children (CCC) centers employ parents of CSHCN as parent coordinators. In addition, the centers have contractual relationships with the coordinators of Parent to Parent of Virginia, the Family to Family Network of Virginia and Medical Home Plus to provide outreach, support, mentorship, and training to parents. They have assisted the Care Connection for Children centers in establishing their family-to-family support services. Parents from Parent to Parent of Virginia provided input into Virginia's state CSHCN plan to meet the Healthy People 2010 goals. Parent focus groups have provided input for various MCH related programs. Family representatives serve on the Regional Perinatal Councils, the Hemophilia Advisory Board, the Fetal Alcohol Spectrum Disorder Task Force, the Virginia Early Hearing Detection and Intervention Advisory Committee and its Parent Subcommittee, and the Virginia Genetics Advisory Committee. OFHS staff also participates in a number of organizations with families such as the Virginia Chapter of the Hemophilia Foundation, Spina Bifida Foundation, Cystic Fibrosis Foundation, Virginia SIDS Alliance,
Virginia Parents Against Lead, and the Virginia Congress of Parents and Teachers.

The federally funded Family to Family Health Information Center (F2FHIC), is based within the VCU Partnership for People with Disabilities, recognized by the federal Administration on Intellectual and Developmental Disabilities as a university center for excellence in developmental disabilities. The Center is a collaborative effort among three organizations: Center for Family Involvement at the Partnership for People with Disabilities, Parent to parent of Virginia, and Medical Home Plus. Each of these organizations has parent staff that have children with special health care needs. Through family support services, the Center for Family Involvement (home to Virginia's Family to Family Network) addresses the need for families to have adequate information, training and support to increase their skills as participants in decision-making processes regarding their child and the broader system of care. The Family to Family Network (Virginia's F2FHIC) works with over 750 families each year to support their development of skills as advocates, mentors and community leaders.

Dana Yarbrough, Executive Director of Parent to Parent of Virginia serves as Virginia's family liaison delegate to the Association of Maternal and Child Health Programs (AMCHP). Dana and Parent to Parent of Virginia currently work closely with Virginia's CSHCN program, Care Connection for Children.

E. State Agency Coordination

In Virginia, state health and human services agencies are organized under the jurisdiction of the cabinet level Secretary of Health and Human Resources who is appointed by the governor. The major health and human services agencies include the Department of Health, the Department of Medical Assistance Services, the Department of Behavioral Health and Developmental Services (formerly the Department of Mental Health, Mental Retardation and Substance Abuse Services), and the Department of Social Services. The Departments of Juvenile Justice and Corrections, and the Department of Education are located under different cabinet secretaries. The Health and Human Resources Secretariat also includes a number of advisory boards that provide opportunities for coordination including the Governor's Advisory Board on Child Abuse and Neglect, the Child Day Care Council and the Governor's Substance Abuse Services Council.

There are also ongoing opportunities to work with Virginia's health education programs and universities. For example, OFHS contracts with the Virginia Commonwealth University's (VCU) Department of Preventive Medicine and Community Health for the services of a faculty level MCH epidemiologist to work within the OFHS. A number of the state universities, including VCU, Virginia Tech, Eastern Virginia Medical School, George Mason University, James Madison University and the University of Virginia have been involved in activities such as trainings, including web-based training, research and report writing, web development and evaluations of programs. OFHS has contracts with university medical centers to provide child development services and CSHCN services through Care Connection for Children. Other contracts with University medical centers include sickle cell, genetic consultation/services and bleeding disorder services.

The Department of Medical Assistance Services (DMAS) continues to bring the public and private sector together to address issues related to service delivery for mothers and children. The Child Health Insurance Advisory Committee (CHIPAC) has representatives from state agencies, private industries, providers and consumers. An OFHS staff is a member of this committee.

An interagency agreement exists between VDH and DMAS for the coordination of Titles V and XIX services. The assignments of responsibilities as stated in the agreement are intended to result in improved use of state government resources and more effective service delivery by assuring that the provision of authorized Medicaid services is consistent with the statutory function and mission of VDH. The agreement has been modified to include a Business Associate Agreement for the purpose of data sharing. The current data sharing projects involve the exchange of blood-lead testing results, eligibility information and decedent information.

/2013/ The data exchange agreement between VDH and DMAS has been amended to include sharing of data to evaluate the Medicaid family planning waiver Plan First enrollment and effectiveness. //2013//

The interagency agreement also includes coordination of Medicaid and the Special Supplemental Nutrition Program for Women, Infants and Children (WIC). The agreement includes mechanisms to assist eligible women and infants to obtain Medicaid coverage and WIC benefits. In addition, the Maternal Outreach Program - a cooperative agreement which expands the VDH Resource Mothers Program - supports the coordination of care and services available under Title V and Title XIX by the identification of pregnant teenagers who are eligible for Medicaid and assisting them with their eligibility applications.

DMAS directs the EPSDT Program and collaborates with the VDH and DSS on specific components of the program. VDH interagency responsibilities include, when appropriate, (1) providing consultation on developing subsystem and data collection modifications and (2) collaborating on (a) modifying the Virginia EPSDT Periodicity Schedule based on Bright Futures, (b) developing materials to be included in the EPSDT Supplemental Medicaid Manual and other provider notices as may be required, (c) providing EPSDT educational activities targeted to local

health departments, (d) implementing strategies that will increase the number of EPSDT screenings, and (e) making available current EPSDT program information and materials that are needed to communicate information to local health department patients.

The Department of Medical Assistance Services, in collaboration with the Departments of Health and Social Services, worked together to link high-risk pregnant women and infants to Baby Care. The program services include outreach and care coordination, education, counseling on nutrition, parenting and smoking cessation and follow-up and monitoring. This program has demonstrated significant improvements in birth outcomes. OFHS staff participate in trainings with DMAS staff on such topics as Bright Futures and EPSDT.

The OFHS contracts with the six regional sites that make up the Statewide Human Services Information and Referral System, administered by the Virginia Department of Social Services, for information and referral services for the MCH Helpline. The system can be accessed from any location in the Commonwealth by dialing "211." The system has been helping Virginians since 1974. This number also serves as the state number for the National Baby Line to provide information and referral for prenatal care. Data documenting maternal and child health related service calls are collected and reported to the OFHS quarterly as required by the contract. This information provides data for future needs assessments and program. Copies of the most recent contracts are on file in the OFHS.

/2012/ The OFHS was awarded a federal First Time Motherhood grant that will focus on linking families with resources through 2-1-1 Virginia. The grant provides funding for community liaisons to work with each of the call centers and local and state agencies to ensure that up to date service information is available to families. The current contracts with the six regional centers will be combined with the First Time Motherhood funded contract with the Virginia Department of Social Services. Data documenting maternal and child health service calls will be collected and reported as in the past. //2012//

Children with Special Health Care Needs

The Division of Child and Adolescent Health's Care Connection for Children (CCC) and the Child Development Clinic Services (CDC) programs have provider agreements with the Department of Medical Assistance Services. Copies of these agreements are on file in the Office of Family Health Services and are reviewed periodically. The CCC and CDC programs bill Medicaid for physician, laboratory, psychological, and hearing services. In the past, DCAH worked with DMAS to revise several state-specific reimbursement codes used for CSHCN.

/2012/ Both the Care Connection for Children (CCC) and the Child Development Clinic Services (CDC) programs are now located in the newly created Division of Child and Family Health. //2012//

/2014/ The structure of the CDC program has transitioned to a public-private partnership for the provision of services. Implementation of the new structure is underway across the state. //2014//

A collaborative relationship has also been established between the Care Connection for Children Program, the Social Security Administration Field Office in Virginia and the Disability Determination Services in the Virginia Department of Rehabilitative Services to enhance each program's roles and responsibilities pertaining to the SSI beneficiaries. Strategies for publicizing each program, facilitating application for benefits and services, expediting referrals, acquisition of medical and other evidence, and reciprocal training about programs available to children with disabilities are continuing.

An interagency agreement exists between VDH and the Department of Education (DOE) for the inclusion of educational consultants as members of the interdisciplinary teams in CDC and CCC centers. The consultants provide liaison services among the clinics and centers, the children's

families and local education agencies serving the children. Duties include administering and interpreting developmental and/or educational evaluations; identifying learning styles, strengths, and weaknesses; recommending educational strategies and modifications; consulting with school personnel regarding modifications in school programs; monitoring and reevaluating progress of the children; and providing staff development. DOE provides the position and funding and contracts with a local school division to provide the supervision and fiscal management of the position. VDH provides the housing and secretarial support and participates in the evaluation of the educational consultants.

The Title V program has established and maintains ongoing interagency collaboration for systems building in some defined areas. The Title V program collaborates with DOE to develop and maintain guidelines for school health services for CSHCN, such as the First Aid Guide for School Emergencies and the Guidelines for Specialized Health Care Procedures. VDH and the American Lung Association have established the Virginia Asthma Coalition to assess needs, share information, and collaborate on the use of available resources.

Other Collaborative Agreements

The Commissioner of the Department of Health serves on the Early Intervention Agencies Committee that was established in 1992 through Section 2.1-760-768 of the Code of Virginia to ensure the implementation of a comprehensive system of early intervention services for infants and toddlers. A representative from the DCAH is an active participant on the Virginia Interagency Coordinating Council (VICC). At the local level, professional staff from the health departments and the Child Development Clinics serve on the local interagency coordinating councils.

The Comprehensive Services Act for At-Risk Youth and Families provides a comprehensive, coordinated, family-focused, child-centered, and community-based service system for emotionally and/or behaviorally disturbed youth and their families throughout Virginia. One representative from VDH/Title V serves on the State Executive Council and another serves on the State and Local Advisory Team (SLAT). Other representatives from the state and local health departments serve on workgroups. Local health departments and/or Child Development Clinic representatives may serve on local community policy and management teams and family assessment and planning teams.

The Title V funded programs are also coordinated with other health department programs that serve a common population group including Immunization, STD/AIDS, and Emergency Medical Services. Immunizations are provided as part of local health department services as are family planning and well-child services. Screening and treatment for STDs are provided in family planning clinics. Family planning, prenatal, and well-child patients may be referred to health department dental services.

OFHS works closely with the Department of Education to implement the Virginia Youth Survey (YRBS). The OFHS Dental program also works closely with local school districts, local schools and WIC programs to provide dental preventive services and surveillance.

The Breastfeeding Advisory Committee is comprised of Virginian stakeholders representing various organizations. The member organizations represent a variety of practice settings and create a multidisciplinary membership. They work in partnership with OFHS to aid in increasing the incidence and duration of breastfeeding among mothers. Representatives include such organizations as the American College of Nurse Midwives, the American Dietetic Association, universities, La Leche League, Medela, the Virginia Nurses Association and others.

The Virginia Chapter of the March of Dimes (MOD) continues as a significant partner in advocating for women and infants. The MOD has worked closely with Virginia's Healthy Start program and with the home visiting programs across the state.

The Commissioner's Infant Mortality Work Group, staffed by OFHS, involves members of the community who have credibility and can influence local families. In addition to medical/health professionals, a wide range of community members such as local educators, civic and business officials, the NAACP, and the AARP are included as members.

Established in 2010 by the Secretary of Health and Human Resources, the Interagency Taskforce on Obesity and Nutrition is a multi-agency work group that is led by the Commissioner of Health. The Taskforce, which has representation from the Departments of Health, Education, Agriculture, Aging, Human Resources Management and Social Services, and the Virginia Foundation for Healthy Youth, was formed to promote wellness and improve nutrition and physical activity, including offering healthier food and beverage choices to state employees.

Intra-agency and interagency collaboration will continue with the above mentioned agencies and others such as, WIC, the Office of Primary Care and Rural Health, Title X -- Federal Family Planning Program, the Commission on Youth, the Virginia Commission on Health Care, the VDH Office of Minority Health and Public Health Policy, the Virginia Community Healthcare Association (formerly the Virginia Primary Care Association), and the Virginia Hospital and Health Care Foundation. In addition, Title V staff will continue to support community-based organizations that have been working to improve the health of the MCH population including organizations such as the Virginia Perinatal Association, the Virginia Association of School Nurses, the Virginia Chapter of the March of Dimes and numerous single disease oriented voluntary organizations.

/2013/ As a result of legislation passed in the 2012 Virginia General Assembly and signed by the Governor, VDH has convened a workgroup with the Departments of Education and Health Professions to revise guidelines for the recognition and treatment of anaphylaxis in the school setting. The workgroup also includes representatives from local school districts, Virginia Chapter-American Academy of Pediatrics, Virginia Association of School Nurses, Medical Society of Virginia, Office of the Attorney General, Virginia Nurses Association, and Virginia Academy of Family Physicians. The legislation requires local school boards to adopt and implement policies for the possession and administration of epinephrine in every school. The legislation also authorizes school nurses and trained school board employees to administer epinephrine to any student believed to be having an anaphylactic reaction. This workgroup is developing changes to the current Virginia School Health Guidelines to address concerns such as issuance of orders; standing protocols for possession, storage, and administration; training needs; requirements for the administration of epinephrine; liability questions; and potential regulatory needs. These new policies must be in effect in every school by the beginning of the 2012-13 school year. VDH will continue to work with DOE regarding training, technical assistance, and potential funding issues to assist schools in the implementation of the new requirements for stock epinephrine possession and administration as required by the Code of Virginia. This legislation and subsequent policies are intended to improve school capacity to respond to anaphylactic reactions and reduce potential mortality associated with these reactions. //2013//

/2014/ The 2013 Virginia General Assembly session yielded legislation, signed by the Governor, requiring that VDH and the Virginia Department of Education (DOE) work together to develop and implement policies for providing educational information regarding eating disorders to parents of students in grades five through 12. The Departments will identify and develop appropriate additions or revisions to "Virginia School Health Guidelines" as well as develop guidelines for school boards regarding the optional development of an eating disorder screening program, training needs and requirements, opt-out and exemption procedures, parental notification procedures for indications of an eating disorder, and any issues requiring statutory or regulatory amendments. The guidelines will be provided to the Superintendent of Public Instruction for dissemination by July 1, 2013. VDH and DOE will also be working with other organizations on these guidelines including local school boards, school superintendents, the National Eating Disorders Association, the Virginia Association of School Nurses, the Virginia Chapter of the American Academy of Pediatrics, and the Virginia Academy of Family Physicians. //2014//

/2014/ Also resulting from legislation passed in 2013, the Department of Conservation and Recreation and the Division of State Parks will convene a stakeholder work group to examine the safety issues associated with moveable soccer goals. VDH will be represented on this work group along with the Department of Education, the Virginia Recreation and Park Society, youth and adult soccer associations, referees associations, semi-professional soccer associations, YMCAs, and the Virginia Retail Merchants Association. The work group will review practices in other states including laws, regulations, policies, and protocols that promote safety for players, especially youth. In addition, the work group will review the current safety practices associated with moveable goals followed by soccer programs sponsored by schools, public parks and recreation programs, and private associations in Virginia. The work group will complete its work and report its findings and any recommendations to the Governor and the General Assembly no later than November 1, 2013. //2014//

/2015/ The 2014 General Assembly session yielded legislation, signed by the Governor, requiring that VDH and the Virginia Department of Education (DOE) work together to amend the guidelines for school policies on concussions in student-athletes. The guidelines will be amended to include a "Return to Learn Protocol" that would require school staff to be alert to cognitive and academic issues among student-athletes with a brain injury and require that school personnel accommodate the gradual return to participation in academic activities based on the recommendation of a concussion-trained health care provider and the appropriated school personnel.

The General Assembly also passed legislation, signed by the Governor, requiring critical congenital heart defect screening of newborns at all hospitals with a newborn nursery. The legislation requires VDH to engage stakeholders in the development of regulations to implement this legislation. VDH has contacted stakeholders, and the first meeting is scheduled for May 9, 2014. //2015//

Title V staff will continue to represent the MCH interests on numerous interagency councils, task forces and committees such as the Governor's Office for Substance Abuse Prevention (GOSAP), the Governor's Council on Substance Abuse Services, and the Governor's Advisory Board on Child Abuse and Neglect, and the Child and Family Behavioral Health Policy and Planning Committee. Title V staff represents the VDH on the legislatively mandated Children's Health Insurance Program Advisory Committee (CHIPAC).

To facilitate the work of the Secretary of Health and Human Resources, the Title V program staff will continue to provide analysis and recommendations to the Governor on legislation before the General Assembly that will directly affect VDH programs and women's and children's health in Virginia. OFHS staff will continue to review and comment on legislation, regulations, and standards of other state agencies from a maternal and child health perspective.

Copies of all interagency agreements are maintained on file in the Office of Family Health Services and are reviewed and amended as required.

See attached list of additional interagency workgroups, committees and advisory groups.
An attachment is included in this section. IIIE - State Agency Coordination

F. Health Systems Capacity Indicators

Health Systems Capacity Indicator 04: *The percent of women (15 through 44) with a live birth during the reporting year whose observed to expected prenatal visits are greater than or equal to 80 percent on the Kotelchuck Index.*

Health Systems Capacity Indicators Forms for HSCI 04 - Multi-Year Data

Annual Objective and Performance Data	2009	2010	2011	2012	2013
Annual Indicator	76.5	73.8	77.0	75.5	77.2
Numerator	79685	75690	75922	77620	
Denominator	104178	102605	98650	102812	
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2013
2013 data not available. Entry is an estimate based on trend.

Notes - 2012
2012 data from birth certificates.

Notes - 2011
2011 data from birth certificates.

Narrative:
The percent of women (15 through 44) with a live birth whose observed to expected prenatal visits are greater than or equal to 80 percent using the Kotelchuck Index has fluctuated in Virginia over the past five years. After hitting a five year low in 2010 of 73.8% of women with a live birth reaching this threshold, the percentage began to rebound to 74.1% in 2011, and 75.5% in 2012.

A persistent racial-ethnic disparity is also evident over time. The disparity is narrowing due to decreased rates in the White, non-Hispanic group and an increased rate in the Hispanic group each year since 2006. However, the rate is consistently lowest in the Hispanic group and among Black, non-Hispanics where no significant progress has been made.

The initiatives at VDH include both overall population and systems based approaches as well as multiple efforts to improve perinatal outcomes through prenatal care among high risk populations such as Medicaid enrollees. VDH continues to lead the state Home Visiting Consortium and directly administer ongoing programs such as the Virginia Healthy Start Initiative (VHSI) and Resource Mothers Programs. VHSI and Resource Mothers have implemented strategies to increase the number of pregnant women who enter prenatal care in the first trimester and keep their prenatal appointments. The Maternal, Infant and Early Childhood Home Visiting project (MIECHV) will continue to fund local sites to improve early childhood systems of care including access to prenatal care. Virginia was awarded an expansion grant to increase funds for this project. Expansion of home visiting services through this project will increase the number of families who are linked to services and resources in Virginia.

In addition, approximately 3.5 million in Title V funding goes to Virginia's health districts to support services including prenatal care. In FY 2013, 27 of the 35 health districts used Title V funds to provide prenatal services and infant mortality reduction initiatives. Most of these funds support the availability of prenatal clinics in 22 of the health districts while other sites provided case management services.

In 2013 VDH lead the development of the Infant Mortality Prevention Strategic Plan (IMSP) in collaboration with over 65 external stakeholders. The plan's five goals include (1) promotion of preconception health, (2) reduction of prematurity births, (3) enhancement of interconception and family planning, (4) prevention of infant injury and support of positive parenting, and (5) improvement of the monitoring, tracking and dissemination of data with objectives and

appropriate strategies that are actionable within the next five years.

IV. Priorities, Performance and Program Activities

A. Background and Overview

During the development of the 2011 Title V Block Grant application, the OFHS Management Team along with a number of our external partners, reviewed the previous Title V priorities, the National and State Performance Measures, the Health Systems Capacity Indicators, the Health Status Indicators as well as needs assessment data that included the qualitative data from the key stakeholder interviews, focus groups, and the district health nurse manager survey. As a result the following eight priorities were identified and will be used to focus OFHS activities and resources during the coming year:

1. Reduce infant mortality.

2. Reduce injuries, violence and suicide.

3. Increase access to dental care and population-based prevention of dental disease across the lifespan.

4. Decrease childhood obesity.

5. Decrease childhood hunger.

6. Improve access to health care services for children and youth with special health care needs by promoting medical homes in practice.

7. Promote independence of young adults with special health care needs by strengthening transition supports and services.

8. Support optimal child development.

In addition to the 18 National Performance Measures, Virginia has identified state level performance measures that will enable the state to monitor progress related to the state MCH priorities. The State Performance Measures include the following:

1. Percent of infants born preterm (gestational age less than 37 weeks).
2. Percent of women ages 18-44 who report good/very/good/excellent health.
3. Percent of 9th - 12th graders who have ever been bullied on school property during the past 12 months.
4. The rate of childhood injury hospitalizations per 100,000 children ages 0 -- 19.
5. Percent of low income children (ages 0 -5) with dental caries.
6. Percent of low income third grade children with dental caries.
7. Percent of women with a live birth who went to a dentist during pregnancy.
8. Percent of children eligible for WIC that are enrolled in WIC, ages 0 -5.
9. Percent of eligible children in daycares that participate in the Child and Adult Care Feeding Programs (CACFP).
10. Percent of eligible children participating in the Summer Food Service Program (SFSP).

B. State Priorities

As part of the 2010 Five-Year Needs Assessment, Virginia developed eight statewide priorities. The following shows the relationship between Virginia's maternal and child health (MCH) priorities and specific measures that are required elements of the annual block grant report: national performance measures (NPM), national outcome measures (NOM), state performance measures

(SPM), state outcome measures (SOM), health systems capacity indicators (HSCI), and health status indicators (HSI). The priorities are not ranked. The issue of health disparities is a cross cutting issue that underlies each of the priorities.

Priority 1: Reduce infant mortality.

Reducing infant mortality is a major initiative of the Health Department. The State Health Commissioner established the Infant Mortality Work Group which not only includes medical/health professionals, but also a wide range of community members such as local educations, civic and business officials, NAACP and the AARP. The workgroup has developed strategies and actions that can be undertaken over the next few years to improve birth outcomes and reduce infant mortality. In 2014 this initiative was broadened from the focus on infant mortality to increasing infants that thrive.

National Outcome Measure 01: Infant mortality rate per 1,000 live births.

National Outcome Measure 02: The ratio of the black infant mortality rate to the white infant mortality rate.

National Outcome Measure 03: The neonatal mortality rate per 1,000 live births.

National Outcome Measure 04: The postneonatal mortality rate per 1,000 live births.

National Outcome Measure 05: The perinatal mortality rate per 1,000 live births plus fetal deaths.
Health Status Indicator 01A: The percent of live births weighing less than 2,500 grams.

Health Status Indicator 01B: The percent of live singleton births weighing less than 2,500 grams.
Health Status Indicator 02A: The percent of live births weighing less than 1,500 grams.

Health Status Indicator 02B: The percent of live singleton births weighing less than 1,500 grams.
Health Systems Capacity Indicator 04: The percent of women with a live birth during the reporting year whose observed to expected prenatal visits are greater than or equal to 80 percent on the Kotelchuck Index.
National Performance Measure 08: The rate of birth (per 1,000) for teenagers aged 15 through 17 years.
National Performance Measure 11: The percent of mothers who breastfeed their infants at 6 months of age.
National Performance Measure 18: Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.

State Performance Measure 01: Percent of infants born preterm (gestational age less than 37 weeks).
State performance Measure 02: Percent of women ages 18-44 who report good/very good/excellent health.

Priority 2: Reduce injuries, violence, and suicide among Title V populations.

Unintentional injuries remain a leading cause of death for persons aged 1 to 64. The majority of these deaths are preventable. In 2010, 2,571 Virginians died as a result of unintentional injuries. Of these 325 were under the age of 24 years old. Suicide took the life of 104 individuals aged 10-24 and 134 individuals aged 0-24 died as a result of homicide. There is also a need for continued efforts to promote healthy behaviors to reduce morbidity and mortality. Concerns relating to injury, violence and suicide were identified in the needs assessment. The key

stakeholders identified the need for expanded prevention and education services for children relating to health issues, and the need for increased education for the prevention of risky behaviors among adolescents. Activities to address this priority include continuing population-based prevention education and provider training on the identification of violence and appropriate documentation and referral.

Health Status Indicator 03A: The death rate per 100,000 due to unintentional injuries among children aged 14 years and younger.

Health Status Indicator 03B: The death rate per 100,000 for unintentional injuries among children aged 14 years and younger due to motor vehicle crashes.

Health Status Indicator 03C: The death rate per 100,000 from unintentional injuries due to motor vehicle crashes among youth aged 15 through 24 years.

Health Status Indicator 04A: The rate per 100,000 of all nonfatal injuries among children aged 14 years and younger.

Health Status Indicator 04B: The rate per 100,000 of nonfatal injuries due motor vehicle crashes among children aged 14 years and younger.

Health Status Indicator 04C: The rate per 100,000 of nonfatal injuries due to motor vehivle crashes among youth aged 15 through 24 years.

National Performance Measure 10: The rate of deaths to children aged 14 years and younger caused by motor vehicle crashes per 100,000 children.

National Performance Measure 16: The rate (per 100,000) of suicide deaths among youths aged 15 through 19.
State Performance Measure 03: Percent of 9th-12th graders who have ever been bullied on school property during the past 12 months.

State Performance Measure 04: The rate of childhood injury hospitalizations per 100,000 children ages 0-19.

Priority 3: Increase access to dental care and population-based prevention of dental disease across the lifespan.

The key stakeholders indicated that there is a growing number of persons who are experiencing limited access to medical and dental care. In 2000, the first Surgeon General's report on oral health identified a "silent epidemic" of dental and oral diseases that burdens some population groups. Oral diseases can place a major burden on low-income and underserved individuals in terms of pain, poor self-esteem, cost of treatment, and lost productivity from missed work or school days. Dental disease and access to dental care is a chronic problem among low-income populations in Virginia. In the public hearings, the need to increase access to dental services for women and children was identified. The lack of access to dental care was also a finding from the key stakeholder interviews and was identified as a significant need by the district health nurse managers. The Dental Health Program's approach to this includes infrastructure building services such as oral health surveillance and recruitment of public health dentists. The program also maintains a quality assurance program for public health dentists. Population-based services include dental education, community water fluoridation, and the fluoride mouth rinse and varnish program. A number of local health departments provide clinical dental services.

National Performance Measure 09: Percent of third grade children who have received protective sealants on at least one permanent tooth.

State Performance Measure 05: Percent of low income children (ages 0-5) with dental caries.

State Performance Measure 06: Percent of low income third grade children with dental caries.

State Performance Measure 07: Percent of women with a live birth who went to a dentist during pregnancy.
Health Systems Capacity Measure 07B: Percent of EPSDT eligible children aged 6 through 9 years who have any dental services during the year.

Priority 4: Decrease childhood obesity.

According to recent data, Virginia has the 27th highest rate of overweight youths ages 10-17. Recent data collected by the Virginia Foundation for Healthy Youth through a youth-reported telephone survey indicates that the highest childhood obesity rates are found in Southwest Virginia, with 28%, closely followed by Southeast Virginia, with 24%. Over the past decade, overweight/obesity has significantly increased in children living within the Commonwealth of Virginia. According to the National Survey of Children's Health in 2003, almost one-fourth (24 percent) of Virginia's children are overweight and 15 percent are at risk for being overweight. The 2007 survey found that approximately 31% of Virginia children ages 10-17 were overweight or obese. Lack of regular physical activity, accessibility to calorie dense foods, larger portion sizes, family lifestyles and lack of interest in health and media messages contribute to the childhood overweight dilemma. In addition, many children live in areas that are not conducive to safe physical activity. This approach to the overweight issue includes population-based services such as public awareness and education and coordinating school and community based physical activity programs as well as an infrastructure level approach to monitor obesity data and policy development.

National Performance Measure 11: The percent of mothers who breastfeed their infants at 6 months of age.
National Performance Measure 14: Percentage of children, ages 2 to 5 years, receiving WIC services with a Body Mass Index (BMI) at or above the 85th percentile.

Priority 5: Decrease childhood hunger.

More than 218,000 children and teens in Virginia face hunger. Adequate nutrition is critical to growth and development of a healthy individual. It is the foundation for physical and mental health. Without adequate nutrition, the body is at risk for multiple diseases and a weakened immune system as well as behavioral problems and mental illness. This is particularly important for children due to the potential for long term consequences. While there are various nutrition programs available, not all are accessed by those who could benefit. Activities to address this priority include monitoring and outreach to assure that children who may eligible for nutritional assistance received those benefits to help improve overall health and well-being.

State Performance Measure 08: Percent of children eligible for WIC that are enrolled in WIC, ages 0 to 5.
State Performance Measure 09: Percent of eligible children in daycares that participate in Child and Adult Care Feeding Programs (CACFP).

State Performance Measure 10: Percent of eligible children participating in the Summer Food Service Program (SFSP)

Priority 6: Improve access to health care services for children and youth with special health care needs by promoting medical home in practice.

Having a medical home has been identified as an important way to ensure that children and especially CSHCN receive the comprehensive care that they need. In the medical home concept a physician provides primary care that is easily accessible, family centered, coordinated, and culturally appropriate. In 2010, approximately 42 percent of Virginia CSHCN received coordinated, ongoing, comprehensive care within a medical home. The key stakeholders and the OFHS management team identified the need for increased access to care and the need for coordinated and culturally-appropriate care. Some activities related to this priority include collaborating with other community agencies and state level groups to expand the availability of medical homes (infrastructure building services) and working with families to ensure that children are referred to a medical home (enabling services).

National Performance Measure 01: The percent of screen positive newborns who received timely follow-up to definitive diagnosis and clinical management for condition(s) mandated by the State sponsored newborn screening programs.

National Performance Measure 03: The percent of children with special health care needs ages 0 to 18 who receive coordinated, ongoing, comperhensive care within a medical home.

Priority 7: Promote independence of young adults with special health care needs by strengthening transition supports and services.

Transitioning CSHCN to adult health and support services have been a challenge faced in Virginia and across the nation. In 2010, 45% of Virginia CSHCN were reported to receive the services necessary to make the transitions to adult life. The Virginia Title V CSHCN program has identified this need as a priority for its MCH program. All CSHCN programs have developed specific tools and monitoring activities to assist with improving transition for CSHCN.

National Performance Measure 06: The percentage of youth with special health care needs who received the services necessary to make transitions to all aspects of adult life, including adult health care, work and independence.

Health Systems Capacity Indicator 08: The percent of State SSI beneficiaries less than 16 years old receiving rehabilitative services from the State CSHCN Program.

Priority 8: Support optimal child development.

Supporting optimal child development is a MCH priority in Virginia which extends across numerious programs and initiatives. The 2007 National survey of Children's Health identified 26% of children in Virginia ages 4 months through 5 years to be at moderate or high risk for developmental, behavioral, or social delays. Title V programs and collaborative efforts across state agencies and community based organizations can help identify risks at early ages and provide and promote appropriate education and intervention to promot optimal child development.

National Performance Measure 12: Percentage of newborns who have been screened for hearing before hospital discharge.

Health Systems Capacity Indicator 02: The percent Medicaid enrollees whose age is less than one year during the reporting year who received at leaset one initial periodic screen.

Health Systems Capacity Indicator 03: The percent State Children's Health Insurance Program enrollees whose age is less than one year during the reporting year who received at least one periodic screen.

C. National Performance Measures

Performance Measure 01: *The percent of screen positive newborns who received timely follow up to definitive diagnosis and clinical management for condition(s) mandated by their State-sponsored newborn screening programs.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2009**	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	100	100	100	100	100
Annual Indicator	100.0	100.0	100.0	100.0	100
Numerator	169	147	107	103	
Denominator	169	147	107	103	
Data Source	Newborn Screening Program	Newborn Screening Program	Newborn Screening Program	Newborn Screening Program	Trend analysis
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2014	**2015**	**2016**	**2017**	**2018**
Annual Performance Objective	100	100	100	100	100

Notes - 2013
2013 data not yet available. Entry/indicator is an estimate based on performance in previous years.

Notes - 2012
2012 data from Virginia Newborn Screening Program.
Numerator = number receiving appropriate follow-up (linked to appropriate specialist)
Denominator = number of confirmed cases

Evidence = info from PCP or specialist, oral or written.

Notes - 2011
2011 data from Virginia Newborn Screening Program.
Numerator = number receiving appropriate follow-up (linked to appropriate specialist)
Denominator = number of confirmed cases

Evidence = info from PCP or specialist, oral or written.

a. Last Year's Accomplishments

During FY 2013, Virginia Newborn Screening Program (VNSP) continued to screen newborns delivered in Virginia for the twenty-eight disorders consistent with the recommendations published by the US Department of Health and Human Services' Secretary's Advisory Committee on Heritable Disorders in Newborns and Children. In Virginia, newborn blood-spot screening is mandated by the Code of Virginia for all infants unless a parent or guardian objects on the grounds that the test conflicts with their religious practices. VNSP works in partnership with Virginia's Division of Consolidated Laboratory Services (DCLS). VNSP staff communicates with the primary healthcare provider (PCP) of the infant within 24 hours of notification from DCLS on presumptive positive screening results and provides guidance concerning additional testing and referrals to specialists. Pediatric specialists in the areas of endocrinology, pulmonology and hematology partner with the PCP to provide care to infants with presumed positive and abnormal screening results. Presumptive positive screenings, abnormal and unsatisfactory results are followed at one, three and six month intervals to assure that confirmed cases were appropriately referred for treatment. VNSP refers diagnosed cases to Care Connection for Children (CCC), a component of the Children with Special Health Care Needs Program. CCC care coordinators assist families of newly diagnosed children in obtaining medically necessary metabolic formulas and required dietary supplements; maximizing available insurance benefits, and making referrals to community-based services.

VNSP has converted to a paper-less system of documentation and communication to PCP. This quality improvement project has demonstrated improvement in efficiency and effect in assuring confidentiality.

Support continued for metabolic treatment centers at Eastern Virginia Medical School, University of Virginia Department of Medical Genetics, and Virginia Commonwealth University. Under contractual agreements, these centers provide consultation for providers to facilitate early diagnosis and treatment of infants with abnormal screening results, laboratory services to monitor blood levels and make recommendations for modification of diet and metabolic formula, patient and family education, coordination of genetic testing for the family to assist in making informed decisions, and provision of data and long-term case management information to the VNSP.

The VNSP Program Manager continued to serve on the New York Mid-Atlantic Consortium for Genetic and Newborn Screening Services (NYMAC) Advisory Council and participated in NYMAC activities and initiatives. The VNSP Senior Nurse became responsible for assuring that Virginia data are correct in the national newborn screening database and on the website.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Maintain screening of twenty-eight inborn errors of body chemistry-metabolic, endocrine, and hematologic.			X	
2. Monitor all abnormal newborn screening results and conduct follow-up per protocol including aggressive follow-up of all critical results.			X	
3. Provide metabolic formulas and modified low protein food products to patients diagnosed through VNSS who are <300% of the federal poverty level.		X		
4. Maintain the Virginia Infant Screening and Infant Tracking System (VISITS) birth defects database and ensure that all newborn screening diagnosed cases are included in VISITS.				X
5. Maintain contracts with medical specialists statewide to provide metabolic treatment and consultation.	X			
6. Refer all newborn screening diagnosed cases to Care		X		

Connection for Children (CCC), the CSHCN program for care coordination.				
7. Continue newborn screening related educational activities to healthcare providers and consumers.				X
8. Distribute the newborn screening Parent Brochure to doctor's offices and requesting birthing hospitals.		X		
9. Review and make recommendations regarding proposed legislation or policies addressing newborn screening issues.				X
10.				

b. Current Activities

VNSP ensures screening of all infants, track and follow up on all abnormal results, assure that confirmed cases are referred in a timely manner, conduct site visits, and provide education and technical assistance. Contracts continue with the metabolic treatment centers. VNSP and the EHDI Program created educational posters for PCP to display for patients. A CME/CEU website for providers on newborn screening is near completion (www.newbornscreeningeducation.org). The VNSP website and Facebook page includes ACT sheets developed by the ACMG. At this time, there have been 2851 "hits" to the Facebook page https://www.facebook.com/VDHGenetics.

Regulations are in process to add screening for Severe Combined Immunodeficiency (SCID) and critical congenital heart disease (CCHD). VNSP and DCLS convened an expert panel of neonatologists to discuss regarding the very low birth weight neonate: laboratory cut-off levels and neonatal adaptation to extrauterine life and its effect on newborn screening results. DCLS and birth certificate data are matched to improve quality of contact and demographic data. The newborn screening device number was added to the electronic birth certificate to assist with surveillance and quality improvement. Staff participated in HRSA & NewSteps projects; supported planning the National Association of Public Health Laboratories (APHL) conference; presented during a HRSA CCHD national meeting; provided input to various list serves; and participated with NYMAC.

c. Plan for the Coming Year

In FY 2015, VNSP will continue to ensure screening of all infants, track and follow up on all abnormal results, assure that confirmed cases are referred into treatment in a timely manner and provide education and technical assistance.

Contracts with metabolic treatment centers will continue. Educational sessions will be conducted, by request and as otherwise needed, to hospital nursing departments. VNSP, in partnership with University of Virginia Continuing Medical Education, will launch an educational website on newborn screening. The website will have modules on CCHD and bloodspot screening, and link to a module on hearing screening. Continuing education credits will be earned upon completion of the modules.

It is anticipated that SCID will be added to the newborn screening panel January 2015. VNSP will finalize parent and professional education materials, provider training, relevant forms, and other materials associated with adding new disorders.

The HRSA demonstration project on CCHD will enter into Year Three. CCHD regulations will be implemented and education will continue to assure CCHD screening becomes a standard of newborn care. The project will be investigating the utility of telemedicine to provide echocardiography for outlying birthing facilities.

The VNSP will continue to enhance use of a paper-less system of documentation and communication to PCP. This system allows desktop faxing and document storage on a secure server, reducing paper and storage needs, as well as the possibility of lost or misplaced records.

Participation in the regional NYMAC collaborative and other national efforts will continue as time and resources allow.

Form 6, Number and Percentage of Newborns and Others Screened, Cases Confirmed, and Treated

The newborn screening data reported on Form 6 is provided to assist the reviewer analyze NPM01.

Total Births by Occurrence:	**101412**					
Reporting Year:	**2012**					
Type of Screening Tests:	**(A) Receiving at least one Screen (1)**		**(B) No. of Presumptive Positive Screens**	**(C) No. Confirmed Cases (2)**	**(D) Needing Treatment that Received Treatment (3)**	
	No.	%	No.	No.	No.	%
Phenylketonuria (Classical)	99700	98.3	45	2	2	100.0
Congenital Hypothyroidism (Classical)	99700	98.3	563	28	28	100.0
Galactosemia (Classical)	99700	98.3	188	3	3	100.0
Sickle Cell Disease	99700	98.3	57	40	40	100.0
Biotinidase Deficiency	99700	98.3	96	1	1	100.0
Cystic Fibrosis	99700	98.3	3948	15	15	100.0
Homocystinuria	99700	98.3	187	0	0	
Maple Syrup Urine Disease	99700	98.3	188	1	1	100.0
beta-ketothiolase deficiency	99700	98.3	4	0	0	
Tyrosinemia Type I	99700	98.3	31	0	0	
Very Long-Chain Acyl-CoA Dehydrogenase Deficiency	99700	98.3	78	0	0	
Argininosuccinic Acidemia	99700	98.3	4	0	0	
Citrullinemia	99700	98.3	4	0	0	
Isovaleric Acidemia	99700	98.3	34	0	0	
Propionic Acidemia	99700	98.3	146	1	1	100.0
Carnitine Uptake Defect	99700	98.3	81	0	0	

3-Methylcrotonyl-CoA Carboxylase Deficiency	99700	98.3	15	1	1	100.0
Methylmalonic acidemia (Cbl A,B)	99700	98.3	146	0	0	
Multiple Carboxylase Deficiency	99700	98.3	146	0	0	
Trifunctional Protein Deficiency	99700	98.3	20	0	0	
Glutaric Acidemia Type I	99700	98.3	4	0	0	
21-Hydroxylase Deficient Congenital Adrenal Hyperplasia	99700	98.3	1563	3	3	100.0
Medium-Chain Acyl-CoA Dehydrogenase Deficiency	99700	98.3	36	8	8	100.0
Long-Chain L-3-Hydroxy Acyl-CoA Dehydrogenase Deficiency	99700	98.3	20	0	0	
3-Hydroxy 3-Methyl Glutaric Aciduria	99700	98.3	15	0	0	
Methylmalonic Acidemia (Mutase Deficiency)	99700	98.3	146	0	0	

Performance Measure 02: *The percent of children with special health care needs age 0 to 18 years whose families partner in decision making at all levels and are satisfied with the services they receive. (CSHCN survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2009**	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	65	70	70	77.1	78
Annual Indicator	59.8	59.8	77.1	77.1	77.1
Numerator					
Denominator					
Data Source	National CSHCN Survey	National CSHCN Survey	National CSHCN Survey	National CSHCN Survey	National CSHCN Survey
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and					

2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2014	**2015**	**2016**	**2017**	**2018**
Annual Performance Objective	80	80	80	80	80

Notes - 2013
For 2011-2015, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. This survey was first conducted in 2001. The same questions were used to generate this indicator for both the 2001 and the 2005-06 CSHCN survey. However, in 2009-2010 there were wording changes and additions to the questions used to generate this indicator. The data for 2009-2010 are NOT comparable to earlier versions of the survey.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

Notes - 2012
For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. This survey was first conducted in 2001. The same questions were used to generate this indicator for both the 2001 and the 2005-06 CSHCN survey. However, in 2009-2010 there were wording changes and additions to the questions used to generate this indicator. The data for 2009-2010 are NOT comparable to earlier versions of the survey.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

Notes - 2011
Indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010.

This survey was first conducted in 2001. The same questions were used to generate this indicator for both the 2001 and the 2005-06 CSHCN survey. However, in 2009-2010 there were wording changes and additions to the questions used to generate this indicator. The data for 2009-2010 are NOT comparable to earlier versions of the survey.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

a. Last Year's Accomplishments
The 2009/10 National Children with Special Health Care Needs Survey indicates that 77.1% of families of CSHCN are partners in decision-making and are satisfied with the services they receive. This outcome is not comparable to prior survey years. Virginia, however, was one of nine states that did score significantly higher than the U.S. percentage of 70.3%.

In FY 2013 Care Connection for Children (CCC) Centers for Excellence conducted a statewide survey of families of children and youth served to determine their level of satisfaction with services received and the impact of those services. General satisfaction was assessed through an item on the survey "Overall, how satisfied are you with the services provided by CCC to your family?" Statewide, the overall satisfaction rate ("very satisfied" and "satisfied" responses) was 95.1%, ranging across the six CCCs from 87.9% to 98.86%.

CSHCN staff partnered with parent organizations including local/regional support groups, Parent to Parent of Virginia, and the federally funded Virginia Family-to-Family (F2F) Network of Virginia. These family organizations and local and state partners collaborate and educate on behalf of children and young adults with special needs and their families, and assist them in obtaining timely access to information, resources, support, and services. Five CCC centers continued to employ parents of CSHCN as parent coordinators and two maintained family resource libraries. The sixth CCC center has a family advisory group in conjunction with the hospital's advisory group. Each CCC continued to have an advisory committee with participation of parents of CSHCN to increase family and community involvement in addressing relevant issues.

In 2013 CSHCN staff facilitated meetings with the CCC Parent Resource Coordinators and the F2F Network of Virginia; they shared best practices and brainstormed how to overcome barriers and challenges. The Parents and the F2F also met with the CCC Program Directors and Physician Consultants to learn more about the impact of the Affordable Care Act on CSHCN, Title V, and to brainstorm about how to improve transition services for CSHCN in Virginia.

In 2013 the Virginia Bleeding Disorders Program (VBDP) continued to provide home therapy education and training for families who chose to do home infusions. It also hosted family networking/educational events and a representative spoke at the National Hemophilia Foundation Annual meeting "More than a Caregiver". This includes helping to ensure that families have access to the medications that they need through insurance case management and the administration of a Pool of Funds. Both the Genetics Advisory Committee and Early Hearing Detection and Intervention (EHDI) Advisory Committee include consumer and/or parent members.

The Pediatric Comprehensive Sickle Cell Program serves children living with sickle cell disease. Parents are involved in decision making regarding the medical treatment of their children, families receive support from a social worker, clinics work closely with families to help address educational needs/challenges, and each clinic has a support group or sponsors at least one social activity yearly. The CSHCN program partners with the Statewide Sickle Cell Chapters of Virginia (SSCCV) to offer a community based program. The SSCCV worked with several local chapters throughout the state to offer social support and to help link families living with sickle cell disease to needed services. They also engaged in a statewide media campaign to increase awareness of the services that they provide for people and families living with sickle cell disease.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Include family members and youth with special needs as members of committees and advisory boards of the CSHCN program.				X
2. Provide family-to-family support as a basic service of Care Connection for Children (CCC) centers.		X		
3. Work with Family to Family Health Information and Education Center and other family organizations to enhance the ability of families to partner in decision making.				X
4. Administer parent satisfaction surveys at CCC centers, Child				X

Development Clinics (CDC), and the Virginia Bleeding Disorders Program (VBDP).				
5. Monitor activities and outcomes; adjust CSHCN state plan for meeting HP 2020 goals as needed.				X
6. Review and make recommendations regarding proposed legislation or policies addressing CSHCN.				X
7.				
8.				
9.				
10.				

b. Current Activities

Parents serve on advisory boards of all CSHCN Programs, continue to be members of CCC teams and will continue to enhance family-to-family support services. VBDP continues to sponsor networking events for families and support parents/caregivers who infuse at home. The CSHCN program continues to partner with the Statewide Sickle Cell Chapters of Virginia (SSCCV). This year, the CSHCN program worked with the SSCCV and one of the local pediatric centers to participate in the FDA Public Meeting on Sickle Cell Disease to hear patient and family perspectives on the health effects and treatment needs of people living with sickle cell disease. The SSCCV continues to work with local chapters throughout the state to link families living with sickle cell disease to needed services.

The F2F Network continues to provide outreach and support to culturally and linguistically diverse families of CSHCN through the use of two part-time parents who serve as cultural liaisons. These positions were established in 2009 with funds from the CSHCN program, and have been sustained by F2F. These two parents provide information/referral services and family-centered training in African American and Latino communities statewide.

The VNSP is currently adding SCID and CCHD to the panel of screened disorders. Families affected by those conditions are included in planning education for providers and parents.

c. Plan for the Coming Year

Strengthening family partnerships will continue to be a high priority for the CSHCN Program. VDH will continue to engage with the F2F Network in their work with cultural liaisons to enhance outreach and information/referral services to parents of minority populations and to train and support cultural brokers to help sustain this outreach effort. The CSHCN staff plan to continue to coordinate meetings with the CCC Parents, the F2F Network, and CCC Program Directors and Medical Consultants in order to provide educational opportunities, as well as to facilitate discussion on topics such as the ACA and CSHCN and improving transition services in Virginia.

Families will continue to serve on advisory boards of all CSHCN Programs. The CCCs will continue to have parents of CSHCN as members of CCC teams and will continue to enhance family-to-family support services. The CCC centers will make changes to best meet needs identified by families on the satisfaction survey. VBDP will continue to support families who infuse at home, and maintain a strong network of social workers to help families meet their insurance needs. The CSHCN program will continue to partner with the SSCCV to offer a community based program. The SSCCV will continue to work with several local chapters throughout the state including the newly established chapter in northern Virginia to offer social support and to help link families living with sickle cell disease to needed services.

As the panel of newborn screening disorders is modified to include SCID and CCHD, families affected by those conditions will continue to participate in planning education for providers and parents. New opportunities will be sought for expanding parental input.

Performance Measure 03: *The percent of children with special health care needs age 0 to 18 who receive coordinated, ongoing, comprehensive care within a medical home. (CSHCN Survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2009**	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	60	65	65	43	43.5
Annual Indicator	43.9	43.9	42.4	42.4	42.4
Numerator					
Denominator					
Data Source	National CSHCN Survey	National CSHCN Survey	National CSHCN Survey	National CSHCN Survey	National CSHCN Survey
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2014	**2015**	**2016**	**2017**	**2018**
Annual Performance Objective	44	45	46	47	48

Notes - 2013
For 2011-2015, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate this indicator for the 2005-06 CSHCN survey. The data for the 2001 and 2005-2006 surveys are not comparable for NPM 3. However, the same questions were used to generate the NPM 3 indicator for both the 2005-2006 and 2009-2010, therefore these two surveys are comparable.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

Notes - 2012
For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate this indicator for the 2005-06 CSHCN survey. The data for the 2001 and 2005-2006 surveys are not comparable for NPM 3. However, the same questions were used to generate the NPM 3 indicator for both the 2005-2006 and 2009-2010, therefore these two surveys are comparable.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as

survey design flaws, respondent classification and reporting errors, and data processing mistakes.

Notes - 2011
Indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010.

This survey was first conducted in 2001. The same questions were used to generate this indicator for both the 2001 and the 2005-06 CSHCN survey. However, in 2009-2010 there were wording changes and additions to the questions used to generate this indicator. The data for 2009-2010 are NOT comparable to earlier versions of the survey.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

a. Last Year's Accomplishments
National Survey of CSHCN results for 2009/10 indicate that 42.4% of all Virginia CSHCN received coordinated, ongoing, comprehensive care within a medical home. Although this figure is slightly lower than the 2005/06 results (43.9%), the difference is not statistically significant. Racial disparities persist across this outcome with White CSHCN most likely to meet this outcome (48.6%) versus Black CSHCN (31.7%) or Hispanic CSHCN (33.1%). Families of CSHCN with the lowest incomes (0-99% Federal Poverty Level) were also least likely to have their CSHCN meet this outcome (29.1%) versus those in families with the highest incomes (400% or greater Federal Poverty Level) (54.9%). While most CSHCN have a usual source for sick or well care (91.9%), the responses related to care-coordination and family-centered care components bring the overall outcome down.

CHSCN in VDH administered programs have high rates of having a medical home. In FY 2013 98.6% of the clients in the CDC network; 96% in the CCC network and 98.3% of clients in VBDP had a primary care provider. About 87% of clients in the Sickle Cell Program (SCP) had a designated primary care provider.

CCC, CDC, SCP, and VBDP staffs continue to assist families in finding medical homes for CSHCN. All children served by these programs were screened to determine if they had a primary care provider. Families without a primary care provider received encouragement to establish a medical home and were informed of choices to obtain one.

On hospital site visits, EHDI and NSP staffs emphasize with nursery staff the significance of identifying a medical home prior to discharge. Increased use of hospitalists in newborn and intensive care nurseries has resulted in some issues with identifying a medical home for many infants; hospital staffs have been responsive to the issue at site visits.

This year the CCC and VBDP staff worked with the Dental Health Program to improve access to dental care for CSHCN. The SWVA CCC has a dental hygienist come to specialty clinics and do oral screenings, varnish and assessments. The primary goal of the hygienist and one RN, trained in screenings and varnish applications through Bright Smiles, is to assist families in having both a medical and a dental home.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Collaborate with other community agencies to expand the				X

availability of medical homes for CSHCN.				
2. CCCs, CDCs, and the Bleeding Disorders Program work with fails to ensure that children served are referred to a medical home and to a dentist.		X		
3. Partner with state AAP, Medical Home Plus, Division of Dental Health, and other organizations to provide training and technical assistance to primary care practices on the medical home concept.				X
4. Monitor activities and outcomes; adjust CSHCN state plan as needed.				X
5. Review and make recommendations regarding proposed legislation or policies addressing CSHCN.				X
6. EHDI and NSP follow-up includes emphasis on medical home.			X	
7. EHDI and NSP staff educate hospital staff on importance of identifying a medical home on newborns prior to discharge.				X
8.				
9.				
10.				

b. Current Activities
CSHCN programs continue to monitor client status and refer families to resources. EHDI and NSP staff continues to promote the importance of a medical home to hospital discharge staff. The SWVA CCC is continuing to conduct oral screenings, vanish and assessments for children age 0 to 18 years of age with a primary goal of assisting children in having a dental home. Staff continues to follow the work of the National Academy for State Health Policy on medical homes.

A significant development in Virginia is that DMAS has expanded managed care Medicaid statewide, and children in foster care are now transitioning to coverage by managed care Medicaid, to facilitate medical home linkage and care coordination.

c. Plan for the Coming Year
CSHCN staff will continue to follow the current work of the National Academy for State Health Policy on medical homes and partner with the Department of Medical Assistance Services to explore ways that Medicaid/SCHIP policy may be used to promote medical homes, particularly in light of implementing the Affordable Care Act. CCC centers, CDC, VBDP, and SCP will continue to monitor the status of clients and refer their clients without a medical home to resources. CCC and VBDP staff will continue to partner with the Dental Health Program on improving access to dental care and promote dental homes for CSHCN. EHDI and NSP staff will continue to promote the importance of a medical home with hospital discharge staff, and will develop and provide training as resources allow.

Performance Measure 04: *The percent of children with special health care needs age 0 to 18 whose families have adequate private and/or public insurance to pay for the services they need. (CSHCN Survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2009**	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	75	75	75	65.2	65.2
Annual Indicator	63.7	63.7	65.2	65.2	65.2
Numerator					

Denominator					
Data Source	National CSHCN Survey	National CSHCN Survey	National CSHCN Survey	National CSHCN Survey	National CSHCN Survey
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2014	**2015**	**2016**	**2017**	**2018**
Annual Performance Objective	67.5	67.5	68	68.5	69

Notes - 2013
For 2011-2015, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. This survey was first conducted in 2001. The same questions were used to generate the NPM 4 indicator for the 2001, 2005-06, and 2009-2010 CSHCN surveys.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

Notes - 2012
For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. This survey was first conducted in 2001. The same questions were used to generate the NPM 4 indicator for the 2001, 2005-06, and 2009-2010 CSHCN surveys.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

Notes - 2011
Indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010.

This survey was first conducted in 2001. The same questions were used to generate this indicator for both the 2001 and the 2005-06 CSHCN survey. However, in 2009-2010 there were wording changes and additions to the questions used to generate this indicator. The data for 2009-2010 are NOT comparable to earlier versions of the survey.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

a. Last Year's Accomplishments

The National CSHCN Survey results for 2009/10 show that 65.2% of all Virginia CSHCN had adequate health insurance coverage. This was an increase from 63.7% in 2005/06, however it is not statistically significant. Virginia and national data show that levels of health insurance adequacy decrease as the number of areas the child qualifies on as CSHCN increase. CSHCN with functional limitations also have higher reported levels of inadequate insurance. No significant differences were reported between those with public versus private insurance. In FY 2013, 99.6% of the CDC network, 87.9% of the CCC network, and 93.7% of VBDP clients had health insurance coverage. In the CCC program, 19.5% of clients under age 16 years were also receiving SSI; and in the VBDP 6.2%, were receiving SSI.

CCCs, CDCs, and VBDP prepared their annual plans based on the national outcomes for CSHCN. All are required to refer all eligible children without insurance to either Medicaid or SCHIP and to refer potentially eligible recipients to SSI. They are also required to follow-up with families to determine the outcome of the applications.

A major component of the CCC program and the VBDP is the provision of insurance case management to assist families in obtaining, understanding, and using health insurance. Emphasis is provided to clients transitioning from pediatric to adult health care to ensure continuous insurance coverage as the client ages out of public insurance or their parents' private insurance. VBDP clients receive assistance through a contract with Patient Services Incorporated (PSI), a non-profit organization with a mission to help people with certain chronic illnesses or conditions locate suitable health insurance coverage to enable them to access optimal medical treatment. PSI also provides assistance to VBDP clients with the cost of health insurance premiums. VBDP included out-of-pocket costs in their contract with PSI to enable families to afford the co-pay costs.

In FY 2013, 216 clients (CCC: 198 and VBDP: 18) received financial assistance from the CSHCN POF, a slight increase from 213 in FY 2012. These clients are those meeting income eligibility criteria who are not eligible for public insurance, do not have private insurance, or whose insurance does not cover the needed service. Medications and durable medical equipment continue to be the most requested POF services. VBDP and CCC assist clients with enrolling in manufacturer compassionate use programs to reduce utilization of the POF. VBDP continues to offer the support of a centralized referral and consultation liaison that is available to all CBDP social workers.

Southwest Virginia became the last region of the state to have managed care Medicaid. SWCCC collaborated with the six managed care organizations (MCO) to teach the staff at the center, and the families served in the 12 counties and two cities, about the new MCOs. The Parent Coordinator has established a section in the resource center for families to keep updated on information about MCOs; this addition has been well received by families. She has also added an area for children with coloring books that the MCOs have developed on healthy habits.

The EHDI program, in partnership with the Department of Education, continued to sponsor a Hearing Aid Loan Bank. The latter arranges for loaner devices and their fitting, for families to use while waiting for a permanent device. In FY 2013, the Bank provided aids to 110 clients for an average duration of seven months. This represents a significant gap-filling service to augment available financial resources for families. During FY 2013, staff worked with DMAS to clarify and communicate Medicaid policy on reimbursement for fitting these devices. This resulted in freeing up funds to serve other clients without such coverage.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Refer 100% of eligible children in the CCCs, CDCs, and the		X		

Bleeding Disorders program to Medicaid, FAMIS, and SSI.				
2. Provide health insurance case management as a basic service of the CCC centers and the Bleeding Disorders Program.		X		
3. Monitor activities and outcomes; adjust the CSHCN state plan as needed.				X
4. Work with other agencies to identify issues and remote obstacles that cause underinsurance.				X
5. Provide financial assistance from the CSHCN Pool of Funds for the uninsured and underinsured clients of CCC and VBDP.		X		
6. Review and make recommendations regarding proposed legislation or policies addressing CSHCN.				X
7. Contract for a Hearing Aid Loan Bank to assist families with temporary aids.		X		
8.				
9.				
10.				

b. Current Activities
CSHCN programs continue to refer all potentially eligible children to Medicaid, SCHIP, compassionate use, and SSI programs and follow-up with families about their applications.

Eligible clients continue to receive assistance from the POF. The VDH CSHCN program will review the POF guidelines for the CCC and VBDP to determine the changes that need to be made as a result of the implementation of the Patient Protection and Affordable Care Act. VBDP will be hosting a meeting of Hemophilia Treatment Center social workers to present VBDP changes that are being made as a result of the Act.

SWCCC maintains the resource center with information on MCOs; care coordinators work with families during open enrollment to assist them in maintaining their insurance. Since the MCOs in Southwest Virginia will be expanding to include all of the foster children with DSS in the fall of 2014, SWVA CCC staff will continue to maintain their relationships and provide updates. The Hearing Aid Loan Bank continues to provide gap-filling services to families of children with hearing loss. The revised Care Coordination Notebook -- Financing and Managing Your Child's Health Care continues to be used, providing an overview of how health insurance works; how to understand and use deductibles and co-insurance; a summary of available public waiver programs; and sample advocacy letters for use with insurers such as an appeal or claim reconsideration.

c. Plan for the Coming Year
CDCs, CCC centers, and VBDP will continue to refer all potentially eligible children to Medicaid, FAMIS, PCIP, compassionate use, and SSI programs and follow-up with families to assure that their applications are processed. They will continue to provide insurance consultation to explore all insurance options including the Affordable Care Act. They will continue to provide annual plans based on the HP 2020 outcomes for CSHCN. The SCP also has social workers who help clients meet their needs when it comes to insurance coverage. The program will continue to educate clients regarding the insurance options that are available to them.

Clients will continue to receive assistance from the CSHCN POF as long as financially feasible. Staffs are assessing the impact of health care reform on the POF and will make changes to CSHCN guidelines as needed. Staff will provide data and information as requested on insurance status and gaps in coverage to child health advocates and policy makers working to increase insurance coverage for children in Virginia. The Hearing Aid Loan Bank will continue to provide gap-filling services to families of children with hearing loss.

The Care Coordination Notebook -- Financing and Managing Your Child's Health Care will continue to be used and distributed in FY 2013 and 2014. It will be assessed for future revisions needed to reflect any changes as a result of implementation of the Affordable Care Act.

With the Center Plan in FY15, SWVA CCC will continue to maintain the resource center with an area devoted to MCOs and update as needed. SWVA CCC will continue to have an area for the children with coloring books supplied by the MCOs regarding healthy habits for the children. Updates will be planned as needed.

Performance Measure 05: *Percent of children with special health care needs age 0 to 18 whose families report the community-based service systems are organized so they can use them easily. (CSHCN Survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2009**	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	94	94	94	67	67
Annual Indicator	89.6	89.6	67	67	67
Numerator					
Denominator					
Data Source	National CSHCN Survey	National CSHCN Survey	National CSHCN Survey	National CSHCN Survey	National CSHCN Survey
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2014	**2015**	**2016**	**2017**	**2018**
Annual Performance Objective	68	68.5	69	69.5	70

Notes - 2013
For 2011-2015, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were revisions to the wording, order, and number of questions used to generate this indicator for the 2005-06 CSHCN survey. The questions were also revised extensively for the 2009-2010 CSHCN survey. Therefore, none of the three rounds of the surveys are comparable.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

Notes - 2012

For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were revisions to the wording, order, and number of questions used to generate this indicator for the 2005-06 CSHCN survey. The questions were also revised extensively for the 2009-2010 CSHCN survey. Therefore, none of the three rounds of the surveys are comparable.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

Notes - 2011
Indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010.

This survey was first conducted in 2001. The same questions were used to generate this indicator for both the 2001 and the 2005-06 CSHCN survey. However, in 2009-2010 there were wording changes and additions to the questions used to generate this indicator. The data for 2009-2010 are NOT comparable to earlier versions of the survey.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

a. Last Year's Accomplishments
The 2009/10 National CSHCN Survey shows that 67% of community-based serve systems are organized so families can use them easily in Virginia. These results are not comparable to prior survey results, and varied on the number of areas for which the child qualified as a CSHCN.

The CSHCN Program maintained the CCC network of six Centers of Excellence. The centers provided information and referral to resources; care coordination; family-to-family support; assistance with the transition from child to adult oriented health care systems; and training and consultation with community providers on CSHCN issues.

In an effort to reduce the overall cost and preserve the Child Development Services (CDC) across the Commonwealth VDH transitioned from a local health department based model to a university or health system clinical model in 2013. The CDC centers transitioned from nine to five regional clinics. The CDC network provided multidisciplinary diagnostic evaluations of children suspected of having developmental and/or behavioral disorders. CDCs offered trainings and technical assistance to providers in the community and served as training sites for psychology students.

The VBDP supported a statewide network of comprehensive care centers for clients of all ages with inherited bleeding disorders and their families. It implemented training for clients, families, and health care professionals and school personnel on several topics including home infusion, new parenting programs, genetic testing and coagulation treatment updates. Collaboration continued with the Virginia Hemophilia Foundation (VHF) and the Hemophilia Association of the Capital Area (HACA) to facilitate training and networking events for clients. Staff from several CBDP provided medical support and education for the VHF's annual "Camp Youngblood" for children and siblings with bleeding disorders at the VHF's family camp.

The SCP helped to support comprehensive services for pediatric clients living with sickle cell disease. There are four contracted Comprehensive Pediatric Sickle Cell Centers serving Virginia. Contracted clinics: partnered with the newborn screening program to confirm the diagnosis of SCD; assured that children are entered into specialty care as soon as possible; provided SCD

related clinical care; worked with families to transition children to adult care; and provided social and educational support to families.

In FY 2013, the CCC network provided care coordination and pool of funds services to 3,392 clients. An additional 1,806 children and their families benefited from CCC information and referral services. The VBDP served 305 clients (170 persons under 21 and 135 persons 21 years and older). The CDC network served a total of 4,180 clients. Multidisciplinary, comprehensive diagnostic evaluations with follow-up medical conferences and care coordination were provided for 2,452 new clients. An additional 391 clients were assessed for eligibility for the Developmental Disability Waiver. Another 1,444 clients received other services, including developmental screens, medical treatment, and family consultations. The SCP clinical network provided services to 1,059 clients (1,007 persons age 0-18 and 52 persons 19 years and older).

CCC staff offered care coordination services to infants diagnosed through newborn screening (bloodspot). All CSHCN staff maintained close working relationships with Early Intervention (EI) programs. VEHDIP staff continued to refer infants diagnosed with hearing loss to EI, and provided training on the 1-3-6 EHDI goals to EI providers.

All of the networks in the CSHCN Program continued to evaluate their services and make changes as needed. Staff worked with families and community agencies to continue to strengthen local systems of care for CSHCN. Child Health Programs staff served on multiple state interagency and public/private work groups and advisory committees.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Provide leadership in planning, developing, and implementing efforts to improve services to CSHCN.				X
2. Provide care coordination for CSHCN from birth through twenty years of age in CCC and persons of all ages in VBDP.		X		
3. Provide a system of services for people with bleeding disorders through the Bleeding Disorders Program.	X			
4. Provide diagnostic and evaluation services for children from birth through twenty years of age through the Child Development Clinics.	X			
5. Partner with others to coordinate care for children with developmental and behavioral programs through the Child Development Clinic network.		X		
6. Monitor activities and outcomes, adjust the CSHCN state plan as needed.				X
7. Participate in statewide committees and interagency councils addressing CSHCN issues.				X
8. Provide training and technical assistance.				X
9. Review and make recommendations regarding proposed legislation and policies addressing CSHCN.				X
10. Provide follow-up on newborn blood spot and hearing screening.		X		

b. Current Activities

CDCs are working to strengthen relationships with other community providers to coordinate services, reduce duplication of services, determine unmet needs, and assure that the children with the greatest need are served. Clinics continue to provide annual plans based on the HP 2020 outcomes for CSHCN.

The CCC centers have continued in their mission to develop family-centered, culturally competent, and community-based systems of referral and care and to simplify access to these systems for families. National case management certification remains a goal for CCC staff; the number is steadily increasing toward the goal of 60%.

VBDP has continued collaboration with the CBDP and VHF to facilitate training and networking events for clients. SCP continues to provide services to families and to conduct educational events locally.

The NSP and EHDI programs have partnered with the EI Program, CCC, and health care provider systems to improve systems for timely diagnosis and referral.

Child Health Programs staff continues to serve on multiple advisory committees and work groups at the state level. This includes representation on the Act Early Team, implementing the Virginia Commonwealth University Autism Spectrum Disorders (ASD) grant to enhance screening, diagnosis, and treatment of ASD.

c. Plan for the Coming Year

CDCs will continue to strengthen relationships with other community providers to coordinate services, reduce duplication of services, determine unmet needs, and assure that the children with the greatest need are served.

The CCC centers will continue in their mission to develop family-centered, culturally competent, and community-based systems of referral and care and to simplify access to these systems for families. National case management certification will continue to be a goal for CCC staff. Mechanisms will be explored to electronically capture the number of persons served by CCC's family to family services.

VBDP will continue collaboration with the CBDP and VHF to facilitate training and networking events for clients. SCP will continue to provide services to families and conduct educational events locally.

The NSP and EHDI programs will continue to partner with the EI Program, CCC, and health care provider systems to improve systems for timely diagnosis and referral.

Child Health Programs staff will continue to serve on advisory committees and work groups at the state level, and will explore appropriate opportunities to support or enhance the implementation of health care reform.

Performance Measure 06: *The percentage of youth with special health care needs who received the services necessary to make transitions to all aspects of adult life, including adult health care, work, and independence.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2009	2010	2011	2012	2013
Annual Performance Objective	45	55	55	47	48
Annual Indicator	37.8	37.8	44.9	44.9	44.9
Numerator					
Denominator					

Data Source	National CSHCN Survey	National CSHCN Survey	National CSHCN Survey	National CSHCN Survey	National CSHCN Survey
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2014	**2015**	**2016**	**2017**	**2018**
Annual Performance Objective	49	50	51	52	53

Notes - 2013
For 2011-2015, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate this indicator for the 2005-06 CSHCN survey. There were also issues around the reliability of the 2001 data because of the sample size. The data for the 2 surveys are not comparable for NPM 6, and findings from the 2005-06 survey may be considered baseline data. However, the same questions were used to generate the NPM 6 indicator for the 2009-2010 survey. Therefore, the 2005-2006 and 2009-2010 surveys can be compared.
All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

Notes - 2012
For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate this indicator for the 2005-06 CSHCN survey. There were also issues around the reliability of the 2001 data because of the sample size. The data for the 2 surveys are not comparable for NPM 6, and findings from the 2005-06 survey may be considered baseline data. However, the same questions were used to generate the NPM 6 indicator for the 2009-2010 survey. Therefore, the 2005-2006 and 2009-2010 surveys can be compared.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

Notes - 2011
Indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010.

This survey was first conducted in 2001. The same questions were used to generate this indicator for both the 2001 and the 2005-06 CSHCN survey. However, in 2009-2010 there were wording changes and additions to the questions used to generate this indicator. The data for 2009-2010 are NOT comparable to earlier versions of the survey.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

a. Last Year's Accomplishments

Data from the National CSHCN survey for 2009/10 indicate that 44.9% of youth with special health care needs in Virginia received services necessary to transition to adult life. This was an increase from the 2005/06 survey result of 37.8% although not statistically significant. Transition continued to be a priority area for CSHCN programs.

Numerous activities have continued to facilitate the development of a transition system to assure that YSHCN participate as decision-makers and as partners; have access to health insurance coverage; and have a medical home that is responsive to their needs. Specific activities are included in the contracts with managers of the clinics and centers in all CCC, CDC, VBDP, and SCP networks. These include identification of all open cases of children age 14 years and older to prioritize the group targeted to receive transition services. CCC and the VBDP worked to identify "adolescent friendly" specialists to assist with transitions. Having educational consultants located in CCC, CDC, hemophilia, and some SCP clinics has enhanced communication with schools regarding transition services for youth.

CDC focused on serving younger children to identify developmental, behavioral, and emotional problems as early as possible. When appropriate, adolescents were invited to participate in the interpretive interview of their evaluation findings and recommendations, either with their parents or separately. Recommendations related to transition to adult life were included. Clients were referred to their local school systems and/or rehabilitative services.

The VDH CSHCN program partnered with the CCC program directors to implement a transition quality improvement project across all 6 of the CCC centers throughout the state. This project involved a transition focused survey that captured information from all CCC staff, including the parent resource coordinators. The major outcome of the survey was the recommendation from staff that part of the transition toolkit be updated to include a new survey to be used with clients and parents.

The SCP distributed and implemented a transition manual to assist clients with the transition process. In total, 217 youth were in the SCP transition program.

The VBDP continued to work with the pediatric clinics throughout the state to transition clients to the Virginia Commonwealth University (VCU) Adult Bleeding Disorders clinic. The VBDP Coordinator helps to facilitate this transfer by maintaining a very close working relationship with each of the pediatric clinics. Clients are transitioned to VCU with their individual plan of care.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Provide transition of services from pediatric to adult health care services in the CCCs, CDCs, Bleeding Disorders and Sickle Cell Programs.		X		
2. Monitor activities and outcomes; adjust the CSHCN state plan as needed.				X
3. Review and make recommendations regarding proposed legislation or policies addressing CSHCN.				X
4.				
5.				
6.				

7.				
8.				
9.				
10.				

b. Current Activities
During this FY the CSHCN program has continued to place an emphasis on transition. Staff has been working with the CCC directors to complete a new transition tool. This project has involved the CCC directors, case managers, and parent coordinators.

The Pediatric Sickle Cell Center at the Children's Hospital of the King's Daughters has created a transition bridge program with Eastern Virginia Medical School to improve transition services for clients. The other three centers continue to utilize the sickle cell transition notebook. Also, the CSHCN program continues to work with Virginia Commonwealth University's research project to demonstrate the effectiveness of patient navigators to improve the percentage of sickle cell disease patients in specialty care (Phase 1) and to improve hydroxyurea initiation and adherence (Phase II) among patients with sickle cell disease.

The VBDP required that each of its centers designate one employee to serve as transition coordinator. The state VBDP coordinator meets with each center on a regular basis via conference call.

c. Plan for the Coming Year
The CSHCN staff is currently working on developing a 1-2 page Transition checklist that Care Coordinators and physicians can use to help families develop their own transition plans. The CSHCN staff plans to meet with the CCC Program Directors, Physician Consultants, and Parent Resource Coordinators statewide in the spring of this year to discuss the newly revised Transition checklist. It is our goal to implement the new Transition checklist in all of the CCCs by the end of 2015.

The SCP will continue to use its transition planning notebook, and the VBDP coordinator will continue to work with each center to transition clients to the VCU adult clinic as needed.

Performance Measure 07: *Percent of 19 to 35 month olds who have received full schedule of age appropriate immunizations against Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza, and Hepatitis B.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2009**	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	87.5	88	88	75	77.5
Annual Indicator	70.3	70.4	74.2	77	71.1
Numerator					
Denominator					
Data Source	National Immunization	National Immunization	National Immunization	National Immunization	National Immunization

	Program	Program	Program	Program	Program
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2014	**2015**	**2016**	**2017**	**2018**
Annual Performance Objective	77.5	78	78.5	79	79.5

Notes - 2013
Data for 2013 is unavailable for this measure. Due to the change in the reported vaccine series (4:3:1:3:3 to 4:3:1:3:3:1) for 2012.

Notes - 2012
Data for 2012 is unavailable for this measure. Due to the change in the reported vaccine series (4:3:1:3:3 to 4:3:1:3:3:1) for 2011.

Notes - 2011
Data for 2011 is unavailable for this measure. Due to the change in the reported vaccine series (4:3:1:3:3 to 4:3:1:3:3:1) for 2010.

a. Last Year's Accomplishments
Immunization data indicate that coverage rates are generally trending flat. In 2012, the rate for 4:3:1:3:3:1 was 70.9%. The Division of Immunization administers the Vaccines for Children program through which many children are eligible to receive immunizations at no or low cost. Two major areas of focus were to improve Health Department Coverage Rates working with private providers and the Head Start Health Advisory Committee. Coverage rates that were targeted included Hepatitis A, Rotavirus, flu vaccines and Pertussis (TDAP).

In FY 2013, Title V continued activities to help increase immunization rates focused on the provision of child care health consulting activities, including assessment. The Title V Early Childhood Projects Coordinator, along with the contracted state child care health consultant, supervised Healthy Child Care Virginia (HCCV) training and technical support activities for public health nurses and other professionals serving as child care health consultants. Key consulting activities are to provide CASA immunization audits and help child care centers institute system changes to support all attendees reaching and maintaining up-to-date immunizations. Staff provided consultation to the Virginia Department of Social Services (DSS) to work with child care providers in developing their knowledge and ability to assure complete immunizations among

child care attendees. A part-time contracted coordinator provided ongoing consultation and technical assistance to the field. Five health districts used Title V funds to support activities related to increasing immunization rates through assessment, early childhood asthma management, and child care health consultant activities.

The Commonwealth established a Virginia text4baby program in 2009 with continuing efforts in 2013 to secure further funding and update messages to increase penetration and use. An educational program of the National Healthy Mothers, Healthy Babies Coalition (HMHB), text4baby delivers timely health tips via a new free mobile phone information service providing timely health information to pregnant women and new mothers during pregnancy and through a baby's first year using text messaging.

Title V funds support case management activities that help increase immunizations. Roanoke health district used some of their Title V allocation to support their CHIP case management program for low-income children ages 0-5. Resource Mothers, a lay-person support program available in 87 communities, continued to assist teen parents in getting their infants properly immunized.

The Virginia Immunization Information System (VIIS), the state immunization registry, continues to be developed through the Division of Immunization, Office of Epidemiology. Other activities included provision of immunizations through all local health departments; development and implementation of local immunization action plans; collaboration with public and private sector partners such as WIC and Medicaid HMOs; and surveillance, CASA assessment and evaluation activities led by the VDH Division of Immunizations, Office of Epidemiology.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Provide funding to local health districts to deliver child care health consultation services to help increase immunization rates.				X
2. Promote Bright Futures Guidelines to increase utilization of preventative health care.				X
3. Support home visiting programs such as CHIP and Resource Mothers.		X		
4. Participate in Project Immunize Virginia Coalition.				X
5. Collaborate with stakeholders to publish information regarding immunization requirements including distribution of New Parent Kits.		X		
6. Review and made recommendations regarding proposed legislation or policies addressing access to health care, particularly related to immunizations.				X
7. Provide support to the Virginia Immunization Information System as needed.				X
8.				
9.				
10.				

b. Current Activities

Title V staff continue to work with the Division of Immunization to promote vaccination in keeping with the recommended schedule. Title V supported activities continue to have a major emphasis on working with child care providers to improve immunization rates and other health indicators. The Early Childhood Project Coordinator and staff sustained the number of active child care health consultants to approximately 150 statewide. In FY 2014, three local health districts are using Title V funds to support child care health and safety. Health Districts review CASA results

to determine how they can work with local child care providers to improve rates within their areas. Education, training, and outreach activities are being conducted for child care and Head Start staff to monitor immunization records.

Title V continues to partner with DSS in reaching child care providers. A bi-annual Child Care Health and Safety electronic newsletter had over 35,000 hits to its web site. It is archived on the VDH web site. Topics focus on timely issues such as the importance of immunizations and keeping medical records up-to-date, health insurance, pandemic flu and disease prevention, vaccine updates, mental-health and social-emotional competence, and working with CSHCN.

Virginia continues to collaborate with the Healthy Mothers, Healthy Babies Coalition and Home Visiting Consortium to promote text4baby throughout the state.

c. Plan for the Coming Year

The part time child care health consultant will continue providing technical assistance to field staff through the end of the State Early Childhood Comprehensive Systems grant cycle. Consultation and partnering with the VDH Division of Immunization, Head Start Collaborative, and DSS Divisions of Child Care Programs and Licensing will continue to assist with infrastructure building and quality enhancement activities. The Child Care Health and Safety Newsletter will be published electronically bi-annually.

Child Health will sustain the partnership as appropriate with the statewide immunization registry as they continue to expand the VIIS system, which currently contains over nine years of immunization histories available to health care providers and schools. In addition to recording immunizations, the system also provides up-to-date recommendations for immunization scheduling, generates recall notices, develops immunization reports, identifies areas of under-immunized populations, and maintains an inventory and ordering module for providers. This is administered through the Office of Epidemiology, Division of Immunization. In the coming year, system programming will be developed to link the results of newborn hearing screening to the immunization registry to make getting test results easier for primary care providers, with a future goal of also linking newborn blood-spot results. The expectation is that this will be an incentive for more primary care practices to participate in the registry and have even better data capture.

VDH maintains the Bright Futures web site (www.healthyfuturesva.com) launched in July 2009. This site uses short videos to personify anticipatory guidance themes and the periodicity visit schedule. The site covers key themes on child development, oral health, healthy weight/nutrition, and medical visits through age four including immunizations. Immunizations for early and middle childhood as well as adolescents were added to the site in 2011. The Bright Futures web site will be maintained and updated; the marketing and promotion plan is updated as resources allow. Outreach to early childhood providers, including childcare have been promoted through DSS and DOE early care and education programs.

Performance Measure 08: *The rate of birth (per 1,000) for teenagers aged 15 through 17 years.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2009**	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	15.6	15.4	12	12	10
Annual Indicator	14.5	12.5	11.1	10.2	10.3

Numerator	2188	1955	1708	1559	
Denominator	151243	156210	153220	152367	
Data Source	VA birth data & NCHS pop estimates	VA birth data & NCHS pop estimates	VA birth data & NCHS pop estimates	VA birth data & NCHS pop estimates	Trend estimate
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2014	**2015**	**2016**	**2017**	**2018**
Annual Performance Objective	9.8	9.5	9.3	9	8.8

Notes - 2013
2013 data not yet available. Entry is an estimate based on performance in previous years.

Notes - 2012
2012 birth data used for number of births to teens. Denominator entry is an estimate based on US Census population measure.

Notes - 2011
2011 birth data used for number of births to teens. Denominator entry is an estimate based on previous year.

a. Last Year's Accomplishments
Virginia has seen a steady decline in the teenage birth rate over the past decade and this trend is significant when considering the decrease that has occurred since 1999. However, in 2005-2007 these decreases appear to have leveled off. Nationally in 2010, a record low for US teens births was reached (ages 15-19 34.3 per 1,000), which represents a decrease of 12% for 15-17 year olds and 9% for 18-19 year olds. In 2010, the teen birth rate in Virginia decreased to a low of 12.7 per 1,000 15-17 year old females. The provisional 2011 estimate is a good indication that Virginia will continue to see a decline in teen births.

Abstinence Education Programs (AEP) aimed at middle school aged youth operated in a total of eleven health districts that applied for and received Title V Abstinence Education funding. This was an increase of two new health districts. In 2012, the Abstinence Education Program served approximately 5,663 students between the ages of 10-14. AEP also revised the Talk2Me Parent toolkit that assists parents in talking with the teens about healthy relationships and sexuality. Over 4,275 kits have been distributed across the state to date.

Family planning clinics provide reproductive health services and education in all local health department clinics. In 2012, family planning clinics served 1,226 adolescents under age 15 and 6,634 adolescents ages 15-17. The adolescents under 15 age group increased 10% from 2011, however the 15-17 year old adolescents decreased 5% from 2011.

The Resource Mothers program through the use of community health workers (CHWs) provides mentoring and educational services to pregnant and parenting teens. One of the goals of this program is to assist the participant avoid a subsequent pregnancy. In FY 2012, there were 831 new enrollees and a total of 1876 were served. A total of 25,760 home visits were conducted. The program reported that 3% of the program participants experienced a rapid repeat pregnancy during the first year postpartum as compared to the national estimated teen repeat pregnancy percentage of 25%.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Coordinate administration of teenage pregnancy prevention programming in seven health districts: Alexandria, Crater, Eastern Shore, Norfolk, Portsmouth, Richmond City, and Roanoke Citey.				X
2. Evaluate teenage pregnancy prevention programs.				X
3. Continue effort to integrate HIV, STD, and teen pregnancy prevention messages.				X
4. Develop the statewide adolescent sexual health plan.				X
5. Develop the skills and capacity of youth service providers to serve the target population through information networks.				X
6. review and make recommendations regarding proposed legislation or policies addressing teens and their access to health care and other health services.				X
7.				
8.				
9.				
10.				

b. Current Activities

The Virginia rate of pregnancies among teen's ages 10-19 years declined by 36.3% from 2008 to 2012. The Virginia Abstinence Education Grant Program currently funds nine health districts and community partners; two different health districts did not renew the MOA, but are hopeful to rejoin the program at a later date. The health districts provide curriculum that are approved by AEP and are evidenced based or evidence informed. Staff coordinated train the trainer workshops for these curricula and conducted site visits to provide technical assistance and program evaluation methods. Staff has continued to provide support for collaborative relationships with other state agencies such as the Youth and Foster Care Division and the Department of Education. Currently, 6,220 English and Spanish Talk2Me toolkits have been distributed throughout the state. A focus group analysis was completed and provided several recommendations.

The Resource Mothers Program continued to provide teen mentoring services to pregnant teens. This program has been supported by state and federal Medicaid administrative funds with federal MCH Block grant supporting the administrative functions. Because the Department of Medical Assistance Services (Medicaid) eliminated funding, the program was forced to reduce the number of teens served. In FY 2013, there were 674 new enrollees and a total of 1461 were served. A total of 29,167 home visits were conducted.

c. Plan for the Coming Year

Central office staff and the AEP Coordinator will continue with providing technical assistance on evidence-based or evidence-informed programming and program evaluation for all internal and external partners. Program staff will research youth development programming and social

networking strategies to communicate with youth and teen populations. The Talk2Me toolkit will also be revised and updated with recommendations from the focus group testing. The abstinence education coordinator will continue to promote the companion toolkit for parents to discuss sexuality and teen pregnancy prevention messages with their teens.

Even though teen pregnancy prevention is not a priority objective in the Thriving Infants Strategic Plan, it will be included in the strategies within the goal regarding interconception care which includes reducing unintended pregnancy and increasing birth intervals. Strategies linking a reproductive life plan and health planning with the use of technological tools will be utilized at VDH family planning clinics and other public and private clinics that serve teens.

Family planning clinics in local health departments will continue to provide reproductive health services and education to teens. The Resource Mothers Program is examining how some of the DMAS funds could be utilized by conducting study of time and effort. If feasible, some funding from the Medicaid administrative funds may be allowed and restored. The Program is also conducting research through funding from the Maternal Infant Early Childhood Home Visiting grant to examine effectiveness of this approach. If this program is deemed evidence-based in the reduction of teen pregnancy, there may be other opportunities for future funding. The Resource Mothers program will continue providing home visiting services to pregnant and parenting teens with the goal of avoiding a repeat pregnancy.

Performance Measure 09: *Percent of third grade children who have received protective sealants on at least one permanent molar tooth.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2009**	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	41	55	55	50	50
Annual Indicator	49.4	49.4	49.4	73.6	73.6
Numerator	44567	44567	44567	66620	66620
Denominator	90299	90299	90299	90504	90504
Data Source	Statewide Dental Assessment	Statewide Dental Assessment	Statewide Dental Assessment	Statewide Dental Assessment	Statewide Dental Assessment
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data				Final	Final

Provisional or Final?					
	2014	**2015**	**2016**	**2017**	**2018**
Annual Performance Objective	52.5	52.5	53	53	53.5

Notes - 2013
Data source is Virginia Statewide 3rd Grade Public School Dental Assessment, 2011/2012. Survey was a sentinel survey of 20 schools from across the Commonwealth. The schools selected for this sentinel survey were primarily in urban/suburban areas of the Commonwealth, possibly leading to an over estimate of dental sealant coverage for the larger weighted sample.

A new open mouth survey is slated to be conducted during the 2014/2015 academic year.

Notes - 2012
Data source is Virginia Statewide 3rd Grade Public School Dental Assessment, 2011/2012. Survey was a sentinel survey of 20 schools from across the Commonwealth. The schools selected for this sentinel survey were primarily in urban/suburban areas of the Commonwealth, possibly leading to an over estimate of dental sealant coverage for the larger weighted sample.

Notes - 2011
Estimate for 2010 not yet available. Data source is Virginia Statewide 3rd Grade Public School Dental Assessment, 2009.

a. Last Year's Accomplishments
Local health department dental clinics provided 27,688 visits for individuals and 107,238 clinical services valued at more than $8.7 million during FY 2013. Approximately 71% of all dental visits were for school-aged children and more than 8,500 dental sealants were placed. The Dental Health Program provided support to the local health department dental clinics through conducting a quality assurance program, assisting with recruitments, collecting patient services data, providing workforce development, and orienting new dental staff. On-site quality assurance clinic reviews were completed for two dental clinics. One district received assistance in recruitment of new dental staff. Eight districts used Title V funds to provide dental services to school age and preschool children to include education and dental varnish placement, as well as sealants.

School-based sealant programs continued in the central region in two VDH health districts (Piedmont and Crater). The dental hygienists provided sealants operating under the new remote supervision practice protocol that allow VDH employed dental hygienists to provide preventive services in underserved areas without the direct or general supervision of a dentist. A total of 170 children were screened in these two districts and 400 sealants were placed. A CDC oral disease prevention grant contributed to funding for sealant program infrastructure.

In FY13, the Dental Health Program was awarded a federal grant (Grants to Support Oral health Workforce Activities) from the Health Resource and Services Administration. This workforce grant provided funding for preventive services programs in Cumberland Plateau, Central Virginia, Lord Fairfax and Southside Health Districts. VDH dental hygienists in these areas operated school-based dental sealant programs and health department fluoride varnish programs, in addition to providing community oral health education.. The Dental health Program provided training, technical assistance and management support to these programs utilizing Title V funds. Two health districts (Lord Fairfax and Southside) had vacant dental hygiene positions for school-based services during this period while recruitment was ongoing. In January 2013 the Lord Fairfax hygiene position was filled and in May 2013 the dental assistant for the team was hired. The Southside hygienist and assistant were hired in April. The remote teams for Cumberland Plateau and Central Virginia health districts screened 652 school children and placed 869 sealants.

A statewide survey of 7,838 third grade children was completed in the school year ending in 2009, which included a sample of 201 schools across the state. VDH used the Basic Screening Survey Tool and assistance from the Association of State and Territorial Dental Directors to complete the survey. Results showed that half of the children examined had a dental sealant on at least one permanent molar. When controlling for other factors, children with dental insurance and treated tooth decay were twice as likely to have dental sealants. Children in the central and eastern regions of the state appeared to have greater access to dental sealants than their peers in the northern region. White children were more likely to have dental sealants than Asian, black or Hispanic children. A follow up to the 2009 Basic Screening Survey was completed on 935 third graders in FY13. "Sentinel" schools from across the State were screened to monitor oral health trends. Data showed a significant improvement in the proportion of third grade children with at least one sealant on a permanent molar.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Seven health districts utilize MCH funding to provide services, including dental sealants.	X			
2. District health department dental programs placed more than 8,500 sealants in FY 2013.	X			
3. Maintain a data entry program to record the number of oral health services provided by local health department dental programs.				X
4. Recruit and orient new dentists; provide on-site review of programs.				X
5. Develop and distribute educational materials regarding dental sealants.	X		X	
6. Train local public health dental staff on pediatric dentistry to provide a competent oral health workforce.		X		
7. Implement policies addressing children's access to dental care through a practice change for dental hygienists.				X
8. Provide education regarding dental sealants and other oral health topics to school-aged children.			X	
9. Continue and expand school-based dental programs.	X			
10.				

b. Current Activities

The DHP supports local dental programs in recruitments, orientations, and technical assistance and in the clinical supervision of community-based preventive services dental hygiene teams. Quality assurance reviews were completed for 8 dental hygiene staffed sites. For the purpose of internal alignment with an evolving mission emphasizing more preventive and population-based programs, VDH initiated a restructuring of dental clinical services from a clinic treatment model to a community-based prevention model. The DHP has led a group of stakeholders to plan the transition of clinical programs to this new model.

In FY 13, legislation was enacted to permit VDH employed dental hygienists throughout the State to work under "remote supervision". This extends the benefit of hygienists to deliver preventive services without requiring a dentist's treatment plan. With all vacant hygiene/assistant positions filled, in FY 14 remote hygienist model programs operated in Lenowisco, Cumberland Plateau, Lord Fairfax, Central Virginia, Southside and Piedmont. To date, hygienists have screened over 2307 children and provided more than 3900 sealants/fluoride varnish to children.

Planning for a statewide 2014-2015 third-grade Basic Screening Survey, to monitor oral health trends, is in progress. The sample size has been estimated to be over 9,000 students. Funding for supplies and travel were included in Virginia's PHHS Block Grant.

c. Plan for the Coming Year

The DHP will continue to focus on population-based activities including oral health education, fluoride rinse, topical fluoride applications, sealant application and promotion and community water fluoridation to reduce the disease burden of tooth decay.

The DHP dental sealant program will continue to expand beyond the existing districts and schools. An increasing emphasis on prevention services and population-based programs will be fully implemented in FY15 with expansion of dental hygienists deployed in the Districts. Their responsibilities will include direct preventive services in schools and community settings as well as education, oral health promotion and linking of identified children with dental caries, to sources of care in the community. Placement of sealants on the teeth of high risk children for prevention of dental decay will be a priority.

VDH will continue to communicate with an external stakeholder group to assure the ongoing availability of dental treatment services through community health centers, free clinics, and other dental providers. It is anticipated that three VDH dental clinics will remain open beyond FY14 in areas that are particularly challenged to meet the oral health needs of low income residents.

Continued funding from the CDC oral disease prevention grant for preventive interventions has been requested to improve management and technical assistance infrastructure for school sealant programs. The completed development of comprehensive plans, including a sealant program plan and a surveillance and evaluation plan, will facilitate targeted expansion of the sealant program in FY15 and beyond. A HRSA Workforce grant also supports oral disease prevention efforts in four communities; providers are supervised, in part, by Title V grant funded staffs.

A statewide basic screening survey of third graders will begin in the fall of 2014. This survey will include a parent questionnaire and an open mouth screening of over 9,000 children chosen as a representative sample of the Commonwealth. Funding for the screening materials and travel are anticipated to be provided by the PHHS Block Grant. Title V MCH funded staffs will be calibrated and provide the manpower for this survey.

Performance Measure 10: *The rate of deaths to children aged 14 years and younger caused by motor vehicle crashes per 100,000 children.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2009**	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	1.9	1.8	1.3	1	1
Annual Indicator	1.4	1.2	1.6	1.2	1.4
Numerator	21	18	25	19	
Denominator	1537640	1532720	1539145	1545288	
Data Source	VA Death data & NCHS pop estimates	VA Death data & NCHS pop estimates	VA Death data & NCHS pop estimates	VA Death data & NCHS pop estimates	Trend estimate

Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2014	**2015**	**2016**	**2017**	**2018**
Annual Performance Objective	1.2	1	0.8	0.5	0.5

Notes - 2013
Data for 2013 not yet available. Entry is an estimate based on trend.

Notes - 2012
Numerator data from 2012 Death Certificate File. Denominator from NCHS population estimates.

Notes - 2011
Numerator data from 2011 Death Certificate File. Denominator from NCHS population estimates.

a. Last Year's Accomplishments
The Injury and Violence Prevention Program coordinates a child passenger safety program that promotes proper safety seat restraint use for children from birth until they transition to the vehicle safety belt; increases risk perception and correct usage of child restraints among parents and care givers through outreach and education; provides proper installation education through community safety seat check stations and events; and addresses financial barriers that prohibit access to safety seats through the Low Income Safety Seat Distribution and Education Program (LISSDEP). The child passenger safety program is funded through state allocated Highway Safety Funds and traffic revenues.

During Federal FY 2013, the program distributed 14,306 safety seats and booster seats to indigent children. In addition, 49 children with mild medical needs were issued medically warranted devices through special accommodations that the program offers. This work was completed by 152 volunteer distribution sites housed primarily within local health departments. The Safety Seat Check Station Program provided routine child passenger safety education and installation assistance for 8,266 safety seats at 110 volunteer sites statewide. The program also inspected 2,203 safety seats and booster seats at 123 one-day safety seat check events throughout the state. The program distributed 167,203 pieces of child passenger safety resource materials.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Coordinate statewide child restrain distribution and education program.				X
2. Disseminate child restrain devices.		X	X	

3. Provide public and provider education materials.		X	X	
4. Review and make recommendations regarding proposed legislation or policies addressing motor vehicle safety issues for children.				X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The Injury and Violence Prevention Program continues to serve as the lead program in the state for child passenger safety issues through the coordination of the Low Income Safety Seat Distribution and Education Program distribution sites and child safety seat check stations. Staff are working to expand services to initiate new Safety Seat Check Stations in areas of overall low seatbelt use and to enhance the First Ride, Safe Ride Program in its support of maternity hospital healthcare providers providing parents' of newborns transportation safety discharge education.

MCH block grant funds were used to enhance the service provided by ten Low Income Safety Seat Distribution and Education Program distribution sites by supplying these sites with a vehicle seat simulator equipped with a retractor dial. As part of this program, it is mandatory that clients receiving a safety seat or booster seat attend a use and installation training session to promote proper safety seat usage. Part of this training consists of hands-on practice to learn the correct method of securing a safety seat with the vehicle seatbelt system and LATCH system. Several distribution sites are challenged with providing this hands-on experience due to parking restrictions, lack of practice vehicles, inclement weather, etc. The vehicle seat simulator overcomes these potential barriers by enabling installation instruction to be conducted in a classroom setting.

c. Plan for the Coming Year

The goal continues to be focused on reducing transportation related injuries and fatalities among children 0-14 years of age in Virginia through the promotion of proper child safety seat restraint use and education. The program will continue efforts to accomplish this goal by: 1) providing safety seats and usage education, in compliance with Virginia Code SS46.2-1097, to eligible families who could otherwise not afford them; 2) providing technical assistance to residents throughout the state on the proper installation of child safety seats; 3) supporting best practice discharge policies at maternity hospitals for newborns and children with special healthcare needs and 4) continuing educational outreach about proper usage to high-risk audiences.

Plans for the upcoming year support the continued operation of the following projects aimed at promoting proper safety seat usage statewide: 1) The Low Income Safety Seat Distribution and Education Program provides free child safety seats and education to indigent families statewide; 2) The Safety Seat Check Station Project provides parents and caregivers with local access to technical assistance in the proper selection and installation of child safety seat/booster seats; 3) The First Ride, Safe Ride project provides child passenger safety training to hospital staff, support for policy/environmental changes and educational materials for parents of newborns; 4) Educational outreach and technical assistance in the form of educational materials (i.e. brochures, poster), a 1-800 information line and exhibits at various community/state events.

New for the coming year are efforts focusing on: 1) training maternity staff to address transportation safety for children with special needs upon discharge and support for related policy/environmental changes; 2) partnering with programs serving teen parents with focused

education and technical assistance; and 3) partnering with the Department of Aging and Rehabilitative Services to leverage efforts related to child passenger safety with their older adult transportation safety efforts to target grandparents.

Performance Measure 11: *The percent of mothers who breastfeed their infants at 6 months of age.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2009**	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	50	51	52	42	50
Annual Indicator	46	42.8	40.8	48.2	54.6
Numerator					
Denominator					
Data Source	National Immunization Program	National Immunization Program	National Immunization Program	National Immunization Program	National Immunization Program
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2014	**2015**	**2016**	**2017**	**2018**
Annual Performance Objective	52.5	55	57.5	60	62.5

Notes - 2013
2013 Data not available. Entry is an estimate based on CDC's Breastfeeding National Immunization Data for birth cohort 2010.

Notes - 2012

2012 Data not available. Entry is an estimate based on CDC's Breastfeeding National Immunization Data for birth cohort 2009.

Notes - 2011
2011 Data not available. Entry is an estimate based on CDC's Breastfeeding National Immunization Data for birth cohort 2008.

a. Last Year's Accomplishments
The Division of Community Nutrition (DCN) continued to partner with the University of Virginia (UVA) Office of Continuing Medical Education to host a web-based training course and performance improvement initiative in lactation management (www.BFConsortium.org). The course offered free continuing education units to physicians, nurses, dietitians, pharmacists, and other healthcare professionals and has been in operation since 2007. Additional modules were added in FY 2013, which increase the offering to 20 continuing education hours. This meets the requirement of maternity care facilities wishing to obtain Baby-Friendly Hospital designation.

VDH's Virginia Breastfeeding Advisory Committee (VBAC), encompassed 24 member organizations, continued to hold quarterly meetings in Richmond during FY 2013. The Advisory Committee continued to make efforts to gain wider representation from other areas such as workplace, insurance companies, and day care centers. Member organizations are working toward achieving the goals of the 2012-2017 strategic plan.

DCN used the funding awarded from the United States Department of Agriculture (USDA) to continue to develop and promote the WIC Breastfeeding Peer Counselor Program in Virginia. USDA funding to develop and manage the program is typically issued in two-year grant funding, but last year it was issued in a three-year grant. DCN continued to recruit and hire new WIC breastfeeding peer counselors. During FY 2012, there were 110 breastfeeding peer counselors throughout Virginia who continue to work within the Virginia WIC Program. VDH held regional conference calls with all WIC breastfeeding peer counselors and all 35 district breastfeeding coordinators each quarter to keep them abreast of policy and procedure changes and updates to the WIC breastfeeding peer counselor program.

DCN finalized the work with the University of Virginia (UVA) Health Systems Department of Pediatrics to conduct research to investigate whether viewing a short, inexpensive prenatal video focused on breastfeeding increases the rate of breastfeeding initiation, duration, and exclusivity among low-income, WIC-eligible women in a US setting both in hospital and following discharge until six months of age. Once informed consent was obtained and the participant was enrolled into the study, an enrollment questionnaire was administered asking baseline data. Participants were then randomized to receive either the intervention (viewing the Injoy Videos' Better Breastfeeding video) or the sham therapy (viewing the Injoy Videos' Your Healthy Pregnancy: Prenatal Nutrition and Exercise video). Research assistants loaded the assigned video for the participant to view at the time of enrollment. Chart reviews were performed to collect data regarding delivery. Follow-up telephone interviews were administered to women delivering their babies at 35 weeks gestation or more at one, three, and six months postpartum to collect data regarding infant feeding practices. Five-Hundred (500) women enrolled into the research study. Statistical analysis began in FY 2013 and continues in FY 2014.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Continue the Virginia Breastfeeding Advisory Committee.				X
2. Continue the Breastfeeding Peer Counselor Program.		X		
3. Participate in the promotion of breastfeeding during Breastfeeding Awareness Month.			X	
4. Distribute breastfeeding educational materials to WIC clients.			X	

5. Review and make recommendations regarding proposed legislation or policies addressing breastfeeding.				X
6.				
7.				
8.				
9.				
10.				

b. Current Activities

DCN is continuing to work with UVA to host the web-based training course in lactation management and the web-based performance improvement initiative. The course provides 20 continuing education hours, which are required for maternity care facilities wishing to obtain Baby-Friendly Hospital designation.

VBAC continues to hold quarterly meetings in Richmond. VBAC began its efforts to collaborate with the Health Commissioner's Infant Mortality Work Group on breastfeeding endeavors by working to increase the number of birthing hospitals in Virginia that are implementing part or all of the 10 Steps to Successful Breastfeeding. The VBAC will also be establishing an annual Quality Improvement Collaborative with funding received through the CDC 1305 grant.

VA WIC Program developed a strategic plan to increase the breastfeeding rates. The VA WIC Program continues to move forward to with efforts to increase the number of International Board Certified Lactation Consultants (IBCLCs) in the WIC Program. VA WIC Program developed an IBCLC internship opportunity for WIC staff.

DCN continues to work with the University of Virginia (UVA) Health Systems Department of Pediatrics to analyze the data collected from the research to investigate whether viewing a prenatal video focused on breastfeeding increases the rate of breastfeeding among low-income women. Five-hundred (500) women enrolled into the research study. Statistical analysis began in FY 2013 and continues in FY 2014.

c. Plan for the Coming Year

DCN will continue to offer the web-based training course in lactation management and web-based performance improvement initiative (www.BFConsortium.org) to promote and emphasize exclusive breastfeeding and achievement of Healthy People 2020 goals. The DCN/UVA partnership will continue to seek grant opportunities and begin to develop materials for publication based on results from PI initiative.

The VBAC will continue to hold quarterly meetings and seek wider representation. The VBAC will continue work on the Strategic Plan for 2012-2017. The VBAC will continue its efforts to collaborate with the Health Commissioner's Infant Mortality Work Group on breastfeeding endeavors by working to increase the number of birthing hospitals in Virginia that are implementing part or all of the 10 Steps to Successful Breastfeeding as part of the Baby-Friendly Hospital Initiative. The VBAC will continue to develop the annual Virginia Maternity Care Quality Improvement Collaborative event with funding received through the CDC 1305 grant. This event will include three high level key stakeholders from each of Virginia's 60 maternity care facilities in an effort dialogue among Virginia to increase breastfeeding practices.

DCN will continue to promote the IBCLC internship opportunity for WIC staff statewide. DCN will continue to manage the BFPC in each of the 35 health districts. DCN continues to seek training opportunities and continuing education for peer counselors to keep them abreast of the latest lactation management research. DCN will continue to hold quarterly regional conference calls with all WIC breastfeeding peer counselors and all 35 district breastfeeding coordinators to update them on policy and procedure changes and WIC breastfeeding peer counselor program

updates. Breastfeeding peer counselors continue to work within the WIC Program to promote and support breastfeeding in each locality. DCN will work to form collaboration between the WIC breastfeeding peer counselor program and Virginia hospitals.

DCN will work with UVA's Department of Pediatrics to continue to finalize the research study on whether viewing a short, inexpensive prenatal video focused on breastfeeding increases the rate of breastfeeding initiation, duration, and exclusivity among low-income, WIC-eligible women. Following data analysis, the final report should be completed by the end of FY 2015.

Performance Measure 12: *Percentage of newborns who have been screened for hearing before hospital discharge.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2009**	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	100	100	100	100	100
Annual Indicator	96.8	96.5	95.6	96.1	98.9
Numerator	99774	99351	97990	97458	98240
Denominator	103061	102934	102525	101412	99346
Data Source	Virginia EHDI program & VA birth data	Virginia EHDI program & VA birth data	Virginia EHDI program & VA birth data	Virginia EHDI program & VA birth data	Virginia EHDI program & VA provisional birth data
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2014	**2015**	**2016**	**2017**	**2018**
Annual Performance Objective	100	100	100	100	100

Notes - 2013
Data from the Virginia Early Hearing Detection and Intervention System, 2013 and the number of provisional occurrent births from Virginia Health Statistics, 2013.

Notes - 2012
Data from the Virginia Early Hearing Detection and Intervention System, 2012, and the number of occurrent births from Virginia Health Statistics, 2012.

Notes - 2011

Data from the Virginia Early Hearing Detection and Intervention System, 2011 and the number of occurrent births from Virginia Health Statistics, 2011.

a. Last Year's Accomplishments
During FY 2013, the Virginia Early Hearing Detection and Intervention Program (VEHDIP) continued to administer the state's newborn hearing screening program as required by the Code of Virginia. VEHDIP continued to make improvements to the Virginia Infant Screening and Infant Tracking System (VISITS), provided technical assistance to hospitals, audiologists, and primary medical providers, and improved follow-up.

VEHDIP continued to make significant improvements in tracking infants in need of follow-up testing and diagnosis. VEHDIP reduced the number of infants lost to follow-up from 64% in 2010 to 17% in 2011, to 8% in 2012. The average age of first follow-up testing decreased from 47 days in 2010, down to 40 days in 2011 and to 35 days in 2012. Hearing loss diagnosis age also saw a dramatic decrease from an average of 235 days in 2010, to 133 days in 2011 down to 129 days in 2012. More infants were diagnosed before 6 months of age than ever before. The percent of infants enrolled in Part-C Early Intervention services increased from 34% in 2010, to 37% in 2011 to 76% in 2012.

VEHDIP conducted its first public awareness campaign through Pandora internet radio for one week. VEHDIP PSA exceeded the industry's own standard in "click" responses by 4%. The VEHDIP website received an average of 3,000 daily hits to its website during that week. VEHDIP launched its Facebook page June 2012, and started advertising on Facebook that year; as a result, the program's reach increased from 835 in July to 100,463 in October. To date, the VEHDIP Facebook page has more than 3,400 followers with an average monthly "Reach" of 38,000 people. VEHDIP started advertising on YouTube January 2013, and the PSA video has been viewed more than 17,000 times.

VEHDIP collaborated with a variety of stakeholders to initiate revisions to the "Can Your Baby Hear?" brochure used by birth hospitals and completed distribution of this brochure. VEHDIP also developed and distributed the "What Can You Baby Hear Now?" brochure for prenatal stakeholders and parents. An educational poster for display by providers was developed and distributed in collaboration with VNSP. VEHDIP collaborated with bordering state programs and providers and developed and implemented a plan for reporting of resident infants born and followed-up in those states. VEHDIP participated in the training of home visitors on the EHDI 1-3-6 goals and provided educational materials to each Resource Mothers, Health Families, and CHIP program statewide.

In 2013 VEHDIP conducted 6 site visits to audiologists and 6 site visits to hospitals and shared data and improvement recommendations at each visit. VEHDIP participated in the national survey of providers; audiologists, ENTs and PCPs, to assess their knowledge on EHDI and received valuable information on training needs for these stakeholders. VEHDIP purchased and distributed the NCHAM Hearing Screener Training Curriculum DVD for hospital hearing screeners. Through a contract and in collaboration with VCU, VEHDIP developed web-base trainings for ENTs and audiologists.

The program applied for and was awarded a continuation Cooperative Agreement from the Centers for Disease Control and Prevention (CDC) for VEHDIP systems' improvements. VEHDIP was also awarded a continuation grant from the Health Resources and Services Administration (HRSA) focused on improving follow-up. This funding supports family-to-family support services program, increased outreach activities to diverse cultures, and increasing awareness and education activities among parents and stakeholders.

VEHDIP continued to fund the Virginia Hearing Aid Loan Bank, managed by Blue Ridge Care Connection for Children, and the Virginia Guide By Your Side family-to-family support program, managed by VCU Partnership for People with Disabilities. Both of these programs continue to be

a valuable resource for families, based on use and results of satisfaction surveys.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Enhance, implement, and evaluate the Virginia Early Hearing Detection and Intervention Program.			X	
2. Maintain and improve the Virginia Infant Screening and Infant Tracking System database.				X
3. Provide training for hospital staff regarding hearing screening.				X
4. Provide hospitals with quarterly updates on program strengths and areas of need.				X
5. Provide an annual report to hospital CEOs.				X
6. Monitor newborn hearing screening results nd ensure retesting as needed.			X	
7. Monitor hearing screenings for out of hospital births.				X
8. Collaborate with other states to track resident infants born in border states.				X
9. Review and make recommendations regarding proposed legislation or policies addressing newborn hearing screening and access to services.				X
10.				

b. Current Activities

The VEHDIP continues to conduct activities related to screening, follow-up, family-to-family support, and process improvements. Site visits continue for technical assistance. Advertisement via YouTube and Facebook continues as does outreach and education to prenatal stakeholders. Guide-By-Your-Side (GBYS) holds trainings that target VEHDIP stakeholders and increases outreach to diverse cultures.

Work continues to link VISITS with the Virginia Immunization Information System (VIIS), to share screening results with PCPs electronically. Early Intervention and VEHDIP will share referral and enrollment information through an automated notification to each local Part-C Coordinator, generated from reporting a permanent hearing loss in VISITS. The first phase of this linkage will be completed in 2014, with the 2nd phase expected to be completed in 2015.

VEHDIP continues to conduct ongoing surveillance of data to provide targeted technical support to hospital staff and audiologists. Hospitals not meeting data reporting requirements receive targeted interventions. VEHDIP implemented the use of Early Hearing Detection and Intervention Pediatric Link to Services (EHDIPALS) and encourage audiologists to register on this site as an approved pediatric diagnostic facility.

VEHDIP continues to conduct quarterly Advisory Committee (AC) meetings and AC Workgroup meetings to address specific gaps in the EHDI 1-3-6 process.

c. Plan for the Coming Year

In FY 2015, the VEHDI Program will continue routine operations. Hospitals will receive quarterly surveillance reports providing feedback on screening, referral, and other reporting performance measures. Hospital staff will continue to be trained in data reporting requirements using VISITS. Six site visits will be conducted as part of a quality improvement initiative. Six site visits to audiology practices will be conducted. Family-to-family support will continue.

The linkage between VISITS and VIIS will be tested and released. VEHDIP will develop provider training for this application. Surveillance reports will be monitored to assess use by providers. Tracking, surveillance, follow-up, and awareness activities will be implemented based on analysis of data.

The 1-3-6 Follow-up Plan will be evaluated with a continued focus on lost to follow-up and lost to documentation. Evaluations will be conducted on the new referral and enrollment process with Early Intervention.

VEHDIP will continue to monitor the entire system for gaps and develop and implement corrective actions for infants with extended NICU stays, access to audiology facilities for families with limited access to services, families of infants that are Medicaid eligible, and infants with a transient and unknown hearing loss. Collaborative efforts with stakeholders will continue to be further developed. VEHDIP will disseminate timely and comprehensive data to healthcare professionals, policymakers, and other stakeholders.

VEHDIP will promote the use of the web-based trainings on the EHDI 1-3-6 goals for otolaryngologists, audiologists, EI Providers, and primary medical providers. VEHDIP will continue to collaborate with the Advisory Committee to monitor trends, address gaps, and improve follow-up services in Virginia.

Performance Measure 13: *Percent of children without health insurance.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2009**	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	4.9	4.8	4.8	8.5	8
Annual Indicator	7.4	7.1	8.4	5.9	5.7
Numerator	146190	143821	157488	111059	107915
Denominator	1981269	2026525	1866712	1879030	1904597
Data Source	Current Population Survey, US Census Bureau	Current Population Survey, US Census Bureau	Current Population Survey, US Census Bureau	Current Population Survey, US Census Bureau	Current Population Survey, US Census Bureau
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					

Is the Data Provisional or Final?				Final	Provisional
	2014	**2015**	**2016**	**2017**	**2018**
Annual Performance Objective	5.5	5.3	5	4.8	4.5

Notes - 2012
State survey data not available.
Data from the Current Population Survey, U.S. Census Bureau for 2011.

Notes - 2011
State survey data not available.
Data from the Current Population Survey, U.S. Census Bureau for 2010.

a. Last Year's Accomplishments
VDH continued to collaborate with state and local partners to help reduce the percent of children without health insurance. VDH programs continued integrating outreach, education, and application assistance where feasible. VDH participated in the state mandated Children's Health Insurance Advisory Committee.

The WebVISION-FAMIS-PlanFirst application link continued to be used by local health departments since statewide implementation began September 2005. This system uses health department eligibility information to populate an application for Virginia's Medicaid and S-CHIP programs known as FAMIS Plus and FAMIS. In FY 2013, four health districts used Title V funds to support clinic-based and case management efforts to identify, refer, and assist with enrollment or re-enrollment processes for publicly funded children's health insurance programs.

In FY 2013, VDH collaborated with DMAS and the Virginia Department of Education (DOE) to promote FAMIS programs at TDap immunization events being held for rising 6th graders at schools, local health departments, and community sites. Also in FY 2013, DMAS expanded managed care Medicaid to all regions of Virginia. This access should help improve continuity of care and medical home services for those children previously covered only by fee-for-service Medicaid. Information regarding publicly supported children's health insurance programs (FAMIS programs for Medicaid and SCHIP) is distributed through the OFHS programs as appropriate and posted on the web site.

VDH also worked with other agencies with the Secretary of Health and Human Resources to promote and collaborate with CommonHelp. CommonHelp is a web portal launched in 2012 which provides for online applications for several health insurance and other benefit programs.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Collaborate with partners to increase enrollment in state sponsored health insurance programs.				X
2. Participate in initiatives and coalitions aimed to reduce uninsured rates.		X		
3. Fund local health districts to support outreach and enrollment activities.		X		
4. Support surveillance, monitoring, and dissemination of data related to children's health and insurance status.				X
5. Maintain and improve data system enhancement to generate public insurance application for potential eligibles served in local				X

health districts.				
6. Review and make recommendations regarding proposed legislation or policies addressing children's access to healthcare.				X
7.				
8.				
9.				
10.				

b. Current Activities
Collaboration continues with multiple state and local partners to reduce uninsured rates by integrating outreach and referral activities into program efforts.

In FY14, DMAS began transitioning children in foster care and adoption programs from fee-for-service to managed care Medicaid. When completed, the vast majority of children in Virginia receiving public insurance will enjoy the benefits of being enrolled with a primary care provider and receiving coordinated care that mirrors those insured commercially. In FY14, Governor McDonnell charged the Department of Social Services with leading the Three Branch Initiative, supported by the National Governor's Association, to (1) improve continuity of health care services; (2) improve provision of trauma-informed behavioral health assessments and services that are evidenced-based and research-informed; (3) improve appropriate use and effective management of psychotropic medications at the child and systems level; and (4) improve educational stability and performance of children in foster care. Representatives from VDH are part of this project to enhance insurance coverage for high-risk populations.

In FY14, DMAS and DSS launched "Cover Virginia", where individuals can apply for public insurance over the phone or on-line. Under the Affordable Care Act, Virginia opted to participate in the federal health insurance exchange. By March 2014, almost 103,000 Virginians had enrolled through the marketplace.

c. Plan for the Coming Year
VDH will continue to collaborate with multiple state and local partners to help reduce uninsured rates. Integrating outreach and referral activities into program efforts as well as participating in the state mandated Children's Health Insurance Advisory Committee will continue. Use of the WebVISION FAMIS link will continue to facilitate enrollment of health department clients into appropriate FAMIS health insurance programs.

During FY15, the transition to Medicaid managed care for children in foster care and adoption assistance will be completed, as will the official work of the Three Branch Initiative to improve systems of care. The partnership across the three branches of government, and across agencies, to continue this work will be sustained.

As implementation of the Affordable Care Acts continues, VDH will work with existing Title V programs to help provide information on implications for clients regarding new health insurance options. The CSHCN programs will identify training needs for care coordination staff on assisting clients with insurance choices, as appropriate.

Performance Measure 14: *Percentage of children, ages 2 to 5 years, receiving WIC services with a Body Mass Index (BMI) at or above the 85th percentile.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and	2009	2010	2011	2012	2013

Performance Data					
Annual Performance Objective	29	29	22	29	28
Annual Indicator	33.5	30.0	30.0	30.2	27.4
Numerator	32617	26425	26371	26425	23009
Denominator	97298	88162	87830	87589	83887
Data Source	WIC Program	WIC Program	WIC Program	WIC Program	WIC Program
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2014	**2015**	**2016**	**2017**	**2018**
Annual Performance Objective	27	26	25	24	23

Notes - 2013
Data from VA WICNet, 2013

Notes - 2012
Data from VA WICNet, 2012

Notes - 2011
Data from VA WICNet, 2011

a. Last Year's Accomplishments
The Healthy Eating and Active Living Program (HEAL) continued its mission to promote healthy eating and activity throughout Virginia by providing funding, educational resources and technical assistance to expand evidence-based obesity prevention efforts, and by supporting the implementation of policy, environmental and system change strategies to prevent obesity as identified in the 2011 Surgeon General's National Prevention Strategy.

HEAL partnered with the Department of Education to pilot "Welnet", an online fitness assessment, and "Five for Life", an evidence-based physical education curriculum for K-12 students. The Five for Life curriculum is designed to improve the fitness levels of students and provide them with the knowledge, skills and abilities to live a fit and healthy life. During the 2013-14 school year, a total of 7 school divisions in high-risk areas received funding to implement "Five for Life" physical education curriculum and the "Welnet" assessment tool. They are: Montgomery County Public Schools, Norfolk County Public Schools, Portsmouth City Public Schools, Isle of Wight County Schools, Charlottesville City Public Schools, Hanover County Public Schools, and Caroline County Public Schools.

HEAL provided funding opportunities to 5 local health districts for the implementation of evidence-based obesity prevention programs addressing policy, systems and environmental changes. Funded health districts are required to implement one or more of 2011 National Prevention Strategies. The projects awarded for funding varied from providing cooking, nutrition education and physical activity classes to overweight WIC children and their families to helping students at one elementary school to increase consumption of fruits and vegetables through school gardening program; offering Color Me Healthy trainings to preschool children and "Healthy Meals and Healthy Families" program in 3rd-5th students; and implementing "Fab 5" Afterschool Physical Activity program in elementary and middle schools.

In March 2013, HEAL sponsored four regional "Color Me Healthy" trainings for Head Start providers, private daycares and preschools. This program reaches children ages four and five with fun, interactive learning opportunities on physical activity and healthy eating.

Between March and May 2013, HEAL hosted three "Building a Wealth of Community Health" regional trainings throughout Virginia to provide skills and resources to facilitate implementation of evidence-based healthy eating/active living, tobacco prevention and diabetes prevention strategies in local communities.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Coordinate with the Department of Education to pilot fitness assessment and evidence-based physical education curriculum in 5 VA school divisions.			X	
2. Provide funding to local health districts to implement evidence-bsed obesity prevention interventions.			X	
3. In partnership with the University of Virginia, VDH launched the Pregnancy Weight Gain guidelines continuing education modules for physicians, nurses, dietitians, and other healthcare providers.			X	
4. Provid business Case for Breastfeeding trainings and resources to worksites promoting worksite breastfeeding.			X	
5. Provide Color Me Healthy trainings to private daycares and preschools promoting healthy eating and physical activities.			X	
6. Conduct media campaigns to promote physical activity and healthy weight for children and women of childbearing ages.			X	
7.				
8.				
9.				
10.				

b. Current Activities

HEAL continues to promote the adoption of healthy behaviors and lifestyles for all Virginians by providing statewide consultation, training and technical assistance on healthy eating, active living and obesity prevention for families and children ages 2-5 years, and participating on various community obesity prevention coalitions to provide obesity prevention presentations.

During the month of January 2014, HEAL launched 95210 for Health? childhood obesity media campaign with the intent of increasing awareness of daily habits that can help children, adults, and families prevent obesity and live healthier lives. It was a five-week education and awareness campaign utilizing a combination of advertising media targeting adults, primarily women, between the ages of 18-49 in Southwest, Central, and Eastern regions of Virginia; these areas of the state have significantly higher rates of obesity and other associated chronic conditions. The media campaign consisted of two 30-second radio advertisements in both English and Spanish, one 30-second and one 10-second television spot, and a 15-second voiceover for Pandora. The Spanish radio advertisement aired on 2 Hispanic radio stations located in Norfolk and Richmond. In addition to the media campaign, bilingual 95210 for Health? prescription tear pads were printed to use with various audiences to aid in dialogue and engage audiences.

c. Plan for the Coming Year

HEAL will continue to promote healthy eating and active living for all Virginians through a multi-sector approach (where we work, live, learn, pray, and play). HEAL hopes to become the central source on healthy eating and active living by building leadership, capacity, and synergy. Additionally, HEAL will work with our partners to motivate and support Virginians in their pursuit of healthy living.

HEAL plans to sponsor another 95210 for Health(r) media campaign in high risk areas and other outreach activities aiming at Virginians with information, tools and resources for promoting healthy eating and access to proper nutrition options. Consistent messaging can improve diet and physical activity habits in children and help them achieve and maintain a healthy weight. Every day, every child should aim for: nine hours of sleep, five servings of vegetables and fruits, two hours or less of screen time outside of school, one hour or more of physical activity, and zero sugary beverages.

HEAL will plan to provide a childhood obesity prevention webinar targeting early child care providers and staff in early child care settings. This webinar will help accentuate the 95210 for Health(r) education and awareness campaign by providing consistent messaging. Topics may include: the need for conducting a self-assessment of current polices, practices, and environmental influences currently offered within each center, customizing needs based on that self-assessment, review of five of the critical components to children's growth and development: adequate sleep; breastfeeding; foods and beverages; screen time; and age-appropriate active play and physical activity.

Performance Measure 15: *Percentage of women who smoke in the last three months of pregnancy.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2009**	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	6.1	6	5.5	5.5	5
Annual Indicator	6.3	5.8	5.1	5.1	4.4
Numerator	6590	6001	5216	5214	
Denominator	104979	102934	102525	102812	
Data Source	VA Birth data	VA Birth data	VA Birth data	VA Birth data	Trend Estimate
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2014	**2015**	**2016**	**2017**	**2018**
Annual Performance Objective	4.8	4.5	4.3	4	3.8

Notes - 2013
2013 data not yet available. Entry is an estimate based on performance in previous years and is a measure of women who ever smoked during pregnancy. In 2012, VA transitioned to the 2003 NCHS format of the birth certificate moving forward VA will be able to report the "Percentage of women who smoke in the last three months of pregnancy".

Notes - 2012
Entry is an estimate based on performance in previous years and is a measure of women who ever smoked during pregnancy. In 2012, VA transitioned to the 2003 NCHS format of the birth certificate moving forward VA will be able to report the "Percentage of women who smoke in the last three months of pregnancy".

Notes - 2011
2011 data. Virginia is still using the old birth certificate, so indicator measures women who ever smoked during pregnancy.

a. Last Year's Accomplishments
2012 Virginia birth certificate data reveals that 5.1% of women self-reported smoking during pregnancy. This reflects a statistically significant downward trend in smoking rates from 8.2% in 2000 to 5.1% in 2012. Pregnancy Risk Assessment Monitoring System (PRAMS) data for 2011 indicates that 7.4% of new mothers smoked in the last three months of pregnancy and 22% reported smoking prior to pregnancy.

Virginia Healthy Start Initiative (VHSI), Resource Mothers, Family Planning, and local health department maternity clinics assessed for tobacco use during pregnancy and the interconception period; provided smoking cessation education and counseling to women who smoke; educated women on the hazards of secondhand smoke for infants and children; and provided referrals to smoking cessation programs. In addition, all of the mentioned programs collaborated and referred pregnant women, especially teens, to the Virginia Quitline. The Quitline has established pregnant women as a priority and provides counseling and support seven days per week. More intensive treatment services are available to callers who have expressed a desire to quit smoking and enroll into a multiple session service with counselor-initiated calls. All services are available in English and Spanish. A separate TTY line is available for the hearing impaired.

In FY 2013, the Resource Mothers Program reported that 169 (23%) newly pregnant teens enrolled reported that they smoked at conception. By the time of delivery, 147 (86%) had stopped smoking.

VHSI provided case management services to 296 high-risk pregnant, postpartum, and interconception women. All women were screened for tobacco use and referred for counselilng if they screened positive. Among the prenatal program participants, 8.2% reported smoking in the last trimester of pregnancy.

During FY2012, central office developed an Infant Mortality Strategic Plan and included smoking cessation among pregnant women as one of the objectives by (1) promoting awareness of the Quit Now Virginia Quitline to pregnant women across the Commonwealth and (2) promoting smoking cessation specific to the Medicaid population within Virginia.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Provide guidance to women in the family planning an prenatal clinic regarding the risk of smoking.		X		
2. Provide case management to pregnant women and refer them to smoking cessation programs.		X		
3. Provide smoking cessation services through the VDH Quitline program.		X		
4. Review and make recommendations regarding proposed legislation or policies addressing smoking and the availability of cessation programs.				X
5. Initiate evaluation of PRAMS data to provide another				X

benchmark defining smoking with Virginia's perinatal population.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The Maternal, Infant and Early Childhood Home Visiting project's 22 sites assess for tobacco use during pregnancy and the interconception period; provide smoking cessation education and counseling to women who smoke; educate women on the hazards of second hand smoke for infants and children; and provide referrals to smoking cessation programs including Virginia's Quitline.

The Virginia Healthy Start/Loving Steps and the Resource Mothers Program continue to monitor smoking status in all participants and reports this measure as a performance measure for the program. Smoking cessation is encouraged and appropriate referrals are made when indicated.

The child fatality review team recently finished a report and found more than 70% of the infants in the review were exposed to secondhand smoke. Half of the mothers smoked while pregnant with the infant who died. The team recommended that tobacco education messages be included in information about smoke as a risk factor for Sudden Unexpected Infant Death (SUID).

The Tobacco Cessation among Pregnant Women implementation team goal is to increase enrollment of pregnant women in the Quitline. The team is working on developing a plan to address the objective and strategies outlined in the Infant Mortality Strategic Plan, specific to tobacco cessation among pregnant women. The team has 26 members with representation from across the states, AAP, FQHC, ACOG, DMAS, MCOs, March of Dimes, and Eastern Virginia Medical School.

c. Plan for the Coming Year

Virginia Healthy Start Initiative (VHSI), Resource Mothers, Family Planning, Maternal, Infant and Early Childhood Home Visiting project, and local health department maternity clinics will continue to assess for tobacco use during pregnancy and the interconception period; provide smoking cessation education and counseling to women who smoke; educate women on the hazards of second hand smoke for infants and children; and provide referrals to smoking cessation programs. In addition, all of the mentioned programs will continue to collaborate and refer pregnant women the Virginia Quitline.

All Resource Mothers Program and VHSI sites will continue implementing Florida State University's "Partnering for a Healthy Baby". This curriculum covers topics relevant to pregnancy, including the message of smoking cessation.

Staff from the DCFH and DHP will continue to develop strategies to promote the awareness of the Quitline in the childbearing age population. Information on the Virginia Quitline will continue to be provided in all home visiting programs.

OFHS staff will continue to move the work forward with the Tobacco Cessation among Pregnant Women implementation team. Action steps will have been developed and prioritized by short term and long term steps. OFHS staff will collaborate with the Tobbacco Use Control Staff to monitor Quit Now Virginia reports to evaluate the number of pregnant women enrollees to ensure action steps are achieving the desired outcomes.

The DCFH is collaborating with the Virginia Chapter of the March of Dimes on StrongStart, a

CMS Innovation project led by Virginia Commonwealth University. The grant is using the CenteringPregnancy prenatal care model within Virginia by participating in the development and adoption of core outcome indicators. CFH provides input and support in the development of a statewide consortium of practitioners engaged in establishing CenteringPregnancy groups to share issues and lessons learned pertaining to model implementation. VDH staff serves on the data subcommittee of this consortium which is developing a statewide evaluation plan including a standard reporting form on birth outcomes. Smoking status will be a performance measure that will be monitored on all participants in this grant.

Performance Measure 16: *The rate (per 100,000) of suicide deaths among youths aged 15 through 19.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2009**	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	5.2	5.2	5.2	5.5	7.5
Annual Indicator	7.6	6.7	8.3	8.5	7.6
Numerator	41	37	45	46	
Denominator	542386	550965	544275	541788	
Data Source	VA Death data & NCHS pop estimates	VA Death data & NCHS pop estimates	VA Death data & NCHS pop estimates	VA Death data & NCHS pop estimates	Trend estimate
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2014	**2015**	**2016**	**2017**	**2018**
Annual Performance Objective	7	6.5	6	5.5	5

Notes - 2013
Data for 2013 not yet available. Entry is an estimate based on trend.

Notes - 2012
2012 data from death certificates and 2012 NCHS population estimates.

Notes - 2011
2011 data from death certificates and 2011 NCHS population estimates.

a. Last Year's Accomplishments
The Injury and Violence Prevention Program maintains a youth-focused suicide prevention program funded by a Substance Abuse and Mental Health Services (SAMHSA) grant. The

program utilizes school, campus, and community based approaches to suicide prevention. The program contracted with two sub-grantees, Bristol Crisis Center and Mental Health America of Central Virginia, to work within their local communities to build and maintain local coalitions, coordinate local awareness campaigns, educate and train school staff on suicide prevention/intervention, and train and provide resources to youth serving community organizations. A third sub grantee affiliated with James Madison University managed the Campus Suicide Prevention Center of Virginia. The Center worked with colleges and universities across the state to build the infrastructure necessary for improved suicide prevention and mental health promotion on Virginia campuses. DPHP also coordinated evidence-based gatekeeper trainings (e.g., Question Persuade Refer [QPR], safeTALK, and Applied Suicide Intervention Skills Training [ASIST]) for K-12 school staff, college faculty, and staff and youth serving community organizations. The trainings are evaluated and have consistently demonstrated that they make participants feel more prepared and inclined to help someone at risk for suicide.

MCH Block grant funds were used to enhance the aforementioned activities during FY13 by targeting additional efforts in partnership with the Campus Suicide Prevention Center of Virginia. The Center adapted a faculty handbook by Cornell University for recognizing and responding to students in distress to reflect Virginia regulations as well as the addition of a postvention section. The handbook was made available to all Virginia campuses in both a hardcopy and e-book version. Funds were also used to support the participation of six Virginia colleges to participate in the national 2013 Healthy Minds study in partnership with the University of Michigan and Survey Sciences Group to collect information on mental health issues on college campuses.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Promote staff gatekeeper training using the evidence based ASIST, Safe Talk, and QPR programs.				X
2. Provide resources and training to initiate implementation of evidence based secondary school suicide assessment and prevention program.		X		
3. Coordinate statewide education to promote recognition of warning signs and encourage help-seeking.		X		X
4. Review and make recommendations regarding proposed legislation or policies addressing suicide prevention and access to services.				X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

DPHP continues to co-chair the Interagency Suicide Prevention Committee with the Department of Behavioral Health and Developmental Services (DBHDS) which has been working on updating Virginia's Suicide Prevention Across the Lifespan Plan.

Analysis of data collected from Virginia colleges that participated in the 2013 Healthy Minds Study is being completed. This will provide information on the mental health of a college's student body (anxiety, eating disorders, depression, and suicide), utilization of on campus mental health resources, and associations between students' mental health and academic outcomes.

c. Plan for the Coming Year
The Youth Suicide Prevention Program plans to build on the previous efforts of the program to reduce youth suicide by implementing statewide public health strategies and developing targeted community level efforts to support policy change and community-clinical linkages to increase the level of prevention efforts, increase identification and referral and ensure continuity of care.

Efforts at the state level will include:
-Continuing to serve as the lead agency for youth suicide prevention.
-Co-chairing the Suicide Prevention Interagency Committee with the Virginia Department of Behavioral Health and Developmental Services.
-Collaborating with the Virginia Department of Education to update the 2003 version of the Board of Education's Suicide Prevention Guidelines, develop supplemental procedures and provide staff training.
-Continuing to support the development of comprehensive suicide prevention efforts on Virginia's 43 public and 115 private colleges and universities through the Campus Suicide Prevention Center of Virginia.
-Establishing a new partnership with the Boys and Girls Club of America and providing targeted suicide prevention gatekeeper trainings for staff development and large scale policy work promoting the development and implementation of suicide prevention plans and protocols inclusive of crisis response, postvention, and contagion mitigation in clubs throughout Virginia.
-Conducting a policy review of emergency departments and inpatient psychiatric units to determine the level of continuity of care and follow-up for youth identified at risk for suicide; develop a plan to improve efforts.
-Coordinating a media campaign to promote utilization of the National Suicide Prevention Lifeline to target youth impacted by TBI.
-Conducting an inventory and assessment of existing LGBT organizations serving youth and TBI service providers of youth to determine the current level of comprehensive suicide prevention programming to aid in planning.
-Providing evidence-based suicide prevention gatekeeper training for targeted groups.

Efforts at the local level will include:
-Providing consultative services and technical assistance with schools currently implementing the Olweus Bullying Prevention program to ensure comprehensive suicide prevention and postvention/crisis response plans are in place.
-Piloting an evidence based means restriction education program in a local emergency department among youth with identified suicide risk.
-Providing training to local health department family planning staff of teen serving clinics on the prevention of suicide and related behaviors.

Performance Measure 17: *Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2009**	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	92	92	92.5	85	86
Annual Indicator	86.1	84.9	89.6	88.1	85
Numerator	1208	1205	1221	1274	
Denominator	1403	1419	1363	1446	
Data Source	VA birth data	VA birth data	VA birth data	VA birth data	Trend estimate

Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2014	**2015**	**2016**	**2017**	**2018**
Annual Performance Objective	87	88	89	90	91

Notes - 2013
2013 data not available. Entry is an estimate based on trend analysis.

Notes - 2012
2012 data from birth certificates and licensure & certification listing of Level III/IV facilities. Invalid birthweights and invalid hospital codes were excluded from the measure.

For 2005 and forward, stricter criteria was used for determining which hospitals are "facilities for high-risk deliveries and neonates" based on the state regulations for licensure of hospitals at the specialty and subspecialty levels of infant care (defined for the measure as Level III and Level IV hospitals).

Notes - 2011
2011 data from birth certificates and licensure & certification listing of Level III/IV facilities. Invalid birthweights and invalid hospital codes were excluded from the measure.

For 2005 and forward, stricter criteria was used for determining which hospitals are "facilities for high-risk deliveries and neonates" based on the state regulations for licensure of hospitals at the specialty and subspecialty levels of infant care (defined for the measure as Level III and Level IV hospitals).

a. Last Year's Accomplishments
In Virginia, 84.9% of very low weight births occurred at facilities for high-risk neonates in 2010. Provisional 2012 data show that 85.8% of very low weight births occurred at facilities for high-risk neonates. There is no significant increase or downward trend.

All local health departments offer pregnancy testing and, if positive, provide patient counseling and referral for prenatal care within two weeks.

The Health Commissioner's Infant Mortality Work Group (HCIMWG) is a diverse workgroup comprised of both lay and healthcare professionals. HCIMWG was convened to examine issues pertaining to infant mortality within Virginia. The role of low weight birth was discussed in the Infant Mortality Strategic Plan that was developed but focus has been shifted away from the regionalized efforts to focus on community efforts to address the contributing factors regarding preterm birth

Resource Mothers and the Virginia Healthy Start Initiative (VHSI)/Loving Steps staff continue to provide information to participants about the signs and symptoms of preterm labor. Teaching about the signs and symptoms of preterm labor is a standard of care for these two programs. Nutrition education and counseling are key components of both of these programs which have goals related to reducing low weight birth. All eligible participants are referred to WIC or other community resources to obtain healthy weight education and counseling.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Local health districts will provide services to reduce low weight birth.	X			
2. VHSI local sites continue outreach to programs and clinics that provide pregnancy testing services to increase referrals for early prenatal care.		X		X
3. VDH staff will provide consultation to the regulatory work group that is reviewing the hospital neonatal regulations.				X
4. Review and make recommendations regarding proposed legislation or policies addressing availability and access to appropriate care.				X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The Commissioner's Infant Mortality Work Group successfully completed their work to develop a strategic plan. The focus of the plan has broadened to encompass the positive concept of creating thriving infants. Following the completion of the strategic plan, the Commissioner's Infant Mortality Work Group has been disbanded and implementation teams are being developed to address specific goals of the plan.

A strategy to use telemedicine to patients in remote and underserved areas is included in that Plan. The Office of Minority Health and Health Equity is supporting the use of telemedicine. Virginia Commonwealth University Health System and the University of Virginia have established partnerships and telemedicine links between local health clinics. This collaboration provides real-time distant consultation services (including live video feed of patient ultrasound studies while being performed) and education to ancillary support staff, health care providers, and community.

c. Plan for the Coming Year

VHSI/LS and Resource Mothers program local sites will continue case management services to participants that include screening and education about access to prenatal care, healthy nutrition during pregnancy and the signs and symptoms of preterm labor.

The Thriving Infants Strategic Plan implementation teams will develop and implement strategies to improve the outcomes of neonatal care throughout the Commonwealth. The strategic plan was developed by the Commissioner's Infant Mortality Work Group.

Health departments that provide perinatal services will continue to provide education regarding the signs and symptoms of preterm labor and healthy nutrition during pregnancy. Twenty- eight of the 35 health districts will use MCH funds to address perinatal issues particularly access to obstetrical care, breastfeeding support and reduction in low weight birth. Staff in the OFHS will continue to provide technical assistance in carrying out district plans.

Collaboration will continue with the Virginia Neonatal Practice Collaborative, a group of neonatology healthcare providers practicing at various high-risk facilities within Virginia, to provide data concerning neonatal mortality and transfer issues.

The Virginia Healthy Start Initiative/Loving Steps also assesses community systems of care

through the work of the consortia. The Title V liaison with the Richmond City Healthy Start regularly attends their Executive Committee meetings and is familiar with any systems issues they identify. Both of these federally funded programs will continue to conduct community outreach in order to engage women at risk for low weight birth into prenatal and other appropriate health care.

Efforts around the promotion of telemedicine will be included as a new Implementation Team under the umbrella of the Thriving Infants Strategic Plan. Staff already have worked with the Mid-Atlantic Telehealth Resource Center (MATRC) on promotion of text4baby and maintain electronic communications. Staff from the MATRC was involved in the development of the Thriving Infants Strategic Plan.

Performance Measure 18: *Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2009**	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	91	91	92	87	87.3
Annual Indicator	82.8	81.9	85.3	83.0	85.8
Numerator	86890	84268	84364	85364	80101
Denominator	104979	102934	98943	102812	93374
Data Source	VA birth data	VA birth data	VA birth data	VA birth data	VA Provisional Birth Data
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2014	**2015**	**2016**	**2017**	**2018**
Annual Performance Objective	87.5	87.8	88	88.5	88.8

Notes - 2013
2013 provisional birth certificate data.

Notes - 2012
2012 birth certificate data.

Notes - 2011
2011 birth certificate data.

a. Last Year's Accomplishments
Based on the provisional birth data from 2012 the percent of infants born to women who received prenatal care in the first trimester was 86.0%.

Within the Department of Health system, 20 local health departments provided prenatal care in FY12. Health departments that do not provide prenatal care have guidelines in place to assist

women in obtaining direct medical services with a local provider. All health departments refer eligible clients to Medicaid and/or Nutrition, Physical Activity and Food Programs for services. In 2012, there were 16,949 maternity patients. This is a slight increase from 15,878 patients last year.

In FY 13, the Resource Mothers Program (RMP) instituted a new participant database system (Well Family Systems) which interfaces with the Virginia Maternal Infant Early Childhood Home Visiting and the Virginia Healthy Start grants. This will enable VDH to track and compare all participants among all three home visiting programs. Of those participants for 2013 enrolled in RMP, 38% received prenatal care in their first trimester. The year to year comparisons that were done in the past applications do not apply to this year.

Virginia Healthy Start Initiative (VHSI) local sites targeted outreach to providers, programs, and clinics that provide pregnancy testing services to increase referrals early in pregnancy to assist women in accessing prenatal care. Of those enrolled in FY 2013, 59.7% of women entered prenatal care in the first trimester.

Resource Mothers conducted outreach to teens and those serving teens in order to increase awareness of the need for prenatal care in the first trimester. Of those enrolled in 2013, 67.5% received prenatal care in their first trimester, which was a decrease over the 2011 rate, 69.9%.

The Health Commissioner's Infant Mortality Workgroup (HCIMWG) is a diverse workgroup comprised of both lay and healthcare professionals. HCIMWG was convened to examine issues pertaining to infant mortality within Virginia. At each HCIMWG meeting, education and discussion on the issues pertaining to perinatal health were conducted. The HCIMWG has been involved in the development and priority setting of goals for the state Infant Mortality Reduction Strategic Plan.

Through data collected in the home visiting programs, Maternal Death Review, and the use of PRAMS and birth certificate data, entry into prenatal care is monitored, issues identified, and community-based recommendations implemented and evaluated for effectiveness.

The Virginia Home Visiting Consortium, an interagency public and private group that includes all those programs using home visiting as a major intervention to improve pregnancy and childhood health, collaborated with VDH to apply for the Maternal, Infant and Early Childhood Home Visiting Grant.

The Health Commissioner's Multivitamin Counseling and Distribution Program distributed folic acid and educated childbearing-age women who seek services at local health departments on the importance of folic acid in the reduction of birth defects.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Educate providers on how to better serve low income women and link them to community resources including health insurance.		X		
2. Educate public on the importance of early prenatal care.			X	
3. Provide education and training to providers on topics that support adequate prenatal care.		X		
4. Provide funding to district health departments to support prenatal care.		X		
5. Through program data in the Well Family System, birth certificates, and the Maternal Death Review process, entry into				X

prenatal care will be monitored, issues identified, and community-based recommendations implemented and evaluated for effectiveness.				
6. VHSI local sites will continue outreach to programs and clinics that provide pregnancy testing services to increase early referral for prenatal care.	X	X		
7. Review and make recommendations regarding proposed legislation or policies addressing access to care.				X
8.				
9.				
10.				

b. Current Activities
The RPC contracts to conduct the Virginia Fetal and Infant Mortality Review program were eliminated.

The FY 2014 funding for the Resource Mothers Program has been reduced due to state budget cuts. Some programs are serving fewer teens and other contractors were terminated. Teens being served in those programs were transitioned to other community resources.

VDH has developed the Thriving Infants Strategic Plan, formerly referred to as the Infant Mortality Reduction Strategic Plan, in collaboration with multiple internal and external stakeholders from across the Commonwealth. Over 65 individuals representing state and private agencies, non-profits, educational research institutions and community organizations have met several times and identified 5 goal topics; (1) preconception (2) preterm birth (3) interconception and family planning (4) positive parenting and (5) data. A comprehensive strategic plan was launched in December 2013. Issues regarding access and utilization of prenatal care were discussed and several strategies proposed. One strategy is to engage community partners and health care providers to promote the benefits of prenatal care beginning in the first trimester.

c. Plan for the Coming Year
Folic acid will continue to be available for all women receiving any service at local health departments. All local health departments will offer pregnancy testing and, if positive, provide patient counseling and referral for prenatal care within two weeks.

The Maternal, Infant and Early Childhood Home Visiting (MIECHV) project will continue to fund twenty-two local sites to improve early childhood systems of care including access to prenatal care. Expansion of home visiting services through this project will increase the number of families who are linked to services and resources in Virginia. The Virginia Home Visiting Consortium will continue to serve as the advisory and interagency leadership group for the Virginia MIECHV project.

The Resource Mothers Program (RMP) will continue providing home visiting services to pregnant and parenting teens and their infants with the goal of improving access and utilization of prenatal, postnatal and infant care. Because of the budget reductions, detailed program and budget analysis has been done to determine ways to set more realistic goals based upon funding, enrollment and history of serving pregnant teens. The number of sites has been reduced from 20 to 16. The University of Virginia School of Nursing is conducting RMP Promising Practices Research to evaluate whether pregnant teens receive better outcomes from home visits compared to similar teens in a control group. Ability to access and use prenatal care is a performance measure in that research.

An implementation team from the VDH Thriving Infants Strategic Plan has been established to promote text4baby which includes messages about seeking and continuing with prenatal care.

Another implementation team will be established regarding pregnancy medical home and increasing ways to assist women to seek early and continuous prenatal care.

An evaluation of the Regional Perinatal Councils has been drafted. Staff are currently working on summarizing the findings from the last year of the Fetal and Infant Mortality Review Program so a complete report can be developed and used for the upcoming needs assessment. The racial/ethnic disparity has been identified as a major concern in access to prenatal care and will be interwoven in all aspects of the Thriving Infants Strategic Plan.

D. State Performance Measures

State Performance Measure 1: *Percent of infants born preterm (gestational age less than 37 weeks completed)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2009**	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective			8	9.5	9.4
Annual Indicator	10.2	10.0	9.5	9.5	9.2
Numerator	10678	9907	9713	9744	8608
Denominator	104979	98924	102525	102812	93374
Data Source	VA Birth Data	VA Birth Data	VA Birth Data	VA Birth Data	VA Provisional Birth Data
Is the Data Provisional or Final?				Final	Provisional
	2014	**2015**	**2016**	**2017**	**2018**
Annual Performance Objective	9.3	9.2	9.1	9	8.9

Notes - 2013
2013 provisional data.

Notes - 2012
2012 Birth data.

Notes - 2011
2011 Birth data.

a. Last Year's Accomplishments
The Virginia Healthy Start Initiative (VHSI) provided case management services to high risk pregnant women including risk assessment, care plan development, and education. In FY 2013, 13.6% of live births among VHSI participants were born at less than 37 weeks gestation compared to 12% in FY2011. Six out of 52 infants were low weight birth (11.5%).

Virginia continued to promote text4baby which provides text informational messages with a public health focus during pregnancy and infancy. As of March 2014, there are over 24,500 Virginia women were enrolled in text4baby. Customized PSAs were developed by the Healthy Mom Healthy Babies program and were distributed to local Virginia media.

The Virginia Hospital and Healthcare Association started a statewide initiative to eliminate early elective deliveries without medical indication. VDH staff served on an Advisory Group that

requested birth hospitals to develop policies and education campaigns for providers and consumers to discourage early elective delivery. In January 2013 the statewide rate was 4.76% but by August 2013, the rate was below the two percent goal.

The Baby Basics Moms Club were initiated as part of the previous now eliminated Regional Perinatal Council activities but have continued with the support of the March of Dimes. The Baby Basics is an evidenced-informed low literacy booklet for pregnant women and intended to assist professionals to provide culturally competent prenatal education. The Moms Clubs has grown from 3 to 5 sites and with input from the OFHS epidemiology staff have improved the exit interview tool in order to collect evaluation data.

b. Current Activities

VHSI local sites provide case management services including screening and education to participants to increase access to prenatal care, community resources and provide education on the importance of delivering a full term infant. A new competitive grant was submitted in January 2014 and is awaiting funding announcement.

State general funds were obtained to customize text4baby with Virginia specific referral numbers and internet sites. Staff are working on adding the additional customized messages that are available which will include topics on newborn screening, safe sleep environment, smoking cessation, and breastfeeding.

VDH staff participates with the CenteringPregnancy statewide Peer-to-Peer Network to increase awareness about group prenatal care, provide technical assistance on the challenges in initiating and maintaining Centering sites, and coordinate educational activities. Staff is collaborating with the Virginia Chapter of the March of Dimes on StrongStart, a CMS Innovation project led by Virginia Commonwealth University. The grant uses the CenteringPregnancy prenatal care model by participating in the development and adoption of core outcome indicators. VDH staff serves on the subcommittee to develop a statewide evaluation plan including a standard reporting form on birth outcomes. There are currently 5 sites participating in the grant.

Baby Basics Moms Club is expanding to 9 sites with continued March of Dimes and local community financial support.

c. Plan for the Coming Year

VHSI local sites will continue risk assessment, care plan development, and case management services to reduce preterm births.

VDH staff including the Virginia Healthy Start staff will continue to share data and information from the previous FIMR data in order to inform the Title V needs assessment.

There are 22 health districts that provide prenatal care and will continue to educate women about signs and symptoms of preterm labor and refer patients to a perinatologist as needed. Telemedicine will continue to be explored and incorporated as the service is available.

OFHS will continue to support the efforts of the Virginia Chapter of the March of Dimes as a member of the Program Services Committee and collaborate when appropriate with their "Healthy Babies are Worth the Wait" campaign. VDH staff will also continue to support the Virginia Hospital and Healthcare Association Early Elective Delivery Initiative and monitor their success through the next few years. VDH will also approach the Virginia Chapter of the Association of Women's Health, Obstetric and Neonatal Nurses (AWHONN) to promote the "Don't Rush Me" campaign to educate consumers by working with the obstetrical and neonatal nurses in the state.

The text4baby Implementation Team will continue promotional activities as outlined in their workplan. Based upon the Virginia utilization data, one to three communities which have low use but high need will be designated for a more targeted campaign. The statewide team members who include health department, managed care organization, and professional groups will solicit from local partners to initiate the campaign. Results from this effort will be used to inform possible replication in other Virginia communities.

VDH will continue to provide assistance and support of the statewide efforts to expand CenteringPregnancy in the state. VDH will monitor and consider the role of Baby Basics Moms Club in prenatal education and its role in the reduction of preterm birth.

State Performance Measure 2: *Percent of women ages 18-44 who report good/very good/excellent health.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2009**	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective			95	90	89
Annual Indicator	88.3	91.9	88.4	91.2	91.2
Numerator	1283273	1328778	1328776	1358883	1358883
Denominator	1453097	1445533	1503939	1489874	1489874
Data Source	Virginia BRFSS	Virginia BRFSS	Virginia BRFSS	Virginia BRFSS	Virginia BRFSS
Is the Data Provisional or Final?				Final	Provisional
	2014	**2015**	**2016**	**2017**	**2018**
Annual Performance Objective	90	91	92	93	93.5

Notes - 2012
Self-rated health status obtained from the Virginia Behavioral Risk Factor Surveillance System (BRFSS), 2011.

Question: Would you say that in general your health is: excellent, very good, good, fair, or poor?

Notes - 2011
Self-rated health status obtained from the Virginia Behavioral Risk Factor Surveillance System (BRFSS), 2011.

Question: Would you say that in general your health is: excellent, very good, good, fair, or poor?

a. Last Year's Accomplishments
In September 2011, VDH received a federal funding through the Pregnancy Assistance Fund (PAF) grant to support pregnant and parenting students at institutions of higher education (IHE) to maintain enrollment in school and ultimately complete their degree. Strategies included the creation of offices of pregnant and parenting student support (OPPSS), the inclusion of evidence informed peer mentoring practices in the program design, a focus on increasing the identification and referral for services of students experiencing domestic violence, sexual assault and stalking issues and the development and implementation of a targeted public awareness campaign. VDH contracted with eight IHEs across the state to implement the strategies on 22 college campuses. Some of the program successes included the establishment of lactation rooms on multiple

campus sites, increased availability of campus-based child care, initiation of one campus-wide campaign per year per site to raise awareness of domestic violence, sexual assault and stalking, assistance provided to over 700 students to obtain emergency housing, food and childcare, a statewide campaign including customized radio and TV ads and a website to aid college students to seek academic and health services.

Resource Mothers and VHSI implemented the Florida State curriculum, including information on physical, emotional, and mental needs of women during the childbearing years. Anticipatory guidance was provided to all clients on healthy behaviors and seeking support and knowledge about areas of health concern.

The 2011 General Assembly appropriated funds to VDH to promote Plan First, the state Medicaid family planning waiver. A full-time Coordinator and a part-time specialist were hired to increase program utilization. Staff conducted trainings for providers and promoted Plan First to agencies and organizations serving eligible women and men. Staff created monthly communications to local health districts outlining enrollment policies and practices, highlighting statewide enrollment outcomes, claims data and strategies for successful utilization.

In partnership with Department of Medical Assistance Services and Department of Social Services, enrollment in Plan First grew from 8,351 women and men in September 2011 to 36,325 women and men as of February 1, 2013. Total paid claims increased from $1,859,875 in CY 2011 to $2,870,470 in CY 2012.

The Every Woman's Life (EWL) program provided breast/cervical screening and diagnostics to low-income, uninsured/underinsured women between the ages of 18-64. Funding for the program was provided through the Center for Disease Control and Prevention's National Breast and Cervical Early Detection Program and state general funds. Services included screening mammograms, clinical breast exams, Pap tests, pelvic exams, follow-up to reach a final diagnosis and case management to ensure women received the recommended screening tests/procedures in a timely manner. In FY13, 171 cases of breast cancer, 114 cases of cervical dysplasia and 2 cases of invasive cervical cancer were diagnosed. Women diagnosed with breast and or cervical cancer/pre-cancer by an authorized EWL provider are eligible for medical assistance under the Breast and Cervical Cancer Prevention and Treatment Act. In FY 13, 254 women that were diagnosed were referred to Medicaid for treatment. EWL focuses on disparate populations including never/rarely screened women, women over age 50, minority women and women with an annual income less than 100% of the Federal Poverty Level.

b. Current Activities

Health districts continue to promote women's health and wellness through maternity, family planning, flu vaccination, and general medical clinics.

Activities related to the PAF grant include evidence informed peer counselor programs, operation of offices of pregnant and parenting student services at targeted institutions of higher education, and implementation of a statewide public awareness campaign to inform the public and link parenting and pregnant students to services. VDH submitted a new grant application which was approved but not funded; all contracts have been terminated but several of the programs such as the support services have been continued through volunteer faculty assistance. All of the print materials promoting the 2-1-1 VIRGINIA referral line have been distributed through the existing home visiting programs.

VDH provides trainings and communication to providers regarding Plan First services. New methods for enrolling eligible women and men at local health districts are being piloted across the state by VDH. Staff continues to collaborate with DMAS and DSS to develop new ways to

increase access to Plan First services while addressing barriers to program enrollment/utilization. Some local health departments have partnered with patient navigators (certified application counselors) to assist with health coverage applications. Currently, Virginia has not taken steps to expand Medicaid, thus Plan First will continue.

c. Plan for the Coming Year

The Maternal, Infant and Early Childhood Home Visiting Program will continue to work to increase efficiency and effectiveness of early childhood home visiting interventions. Evidence-based models and operations in the existing early childhood program structure will be monitored to better serve each family's needs.

VDH will continue to promote, enroll and increase utilization of Plan First in partnership with DSS and DMAS. VDH will continue to promote the program to agencies and organizations serving eligible women and men and share strategies for successful enrollment and utilization. VDH local health district staff will continue to educate patients about Plan First and work closely with local DSS offices to improve application accuracy and increase enrollment. Eligibility staff in local health districts will continue to assist in securing coverage whether through Plan First, Medicaid, FAMIS or a plan through the Health Insurance Marketplace. If Medicaid expansion occurs in Virginia, the Plan First program will be phased-out.

VDH will continue to provide breast and cervical screening services to low-income, uninsured/underinsured women between ages 18-64. New efforts will focus on implementing evidence-based strategies to raise awareness on routine screening and health systems change strategies (client reminder systems) to ensure appropriate and timely screenings and follow-up are received.

Obesity prevention programs targeting women of childbearing ages will continue, expanding in Healthy Community sites across Virginia. Smoking cessation in childbearing and pregnant women is included as a priority objective in the VDH Infant Mortality Reduction Strategic Plan.

State Performance Measure 3: *Percent of 9th-12th graders who have ever been bullied on school property during the past 12 months.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2009**	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective			15	22	20
Annual Indicator	22.0	22.0	22.0	22.0	20.3
Numerator	163	163	315	315	291
Denominator	741	741	1435	1435	1435
Data Source	Virginia Youth Survey	Virginia Youth Survey	Virginia Youth Survey	Virginia Youth Survey	Virginia Youth Survey
Is the Data Provisional or Final?				Final	Provisional
	2014	**2015**	**2016**	**2017**	**2018**
Annual Performance Objective	20	18	18	16	16

Notes - 2012
Data from the 2011 Virginia Youth Survey.

Notes - 2011
Data from the 2011 Virginia Youth Survey.

a. Last Year's Accomplishments
The VDH Injury and Violence Prevention Program maintains a youth-focused bullying prevention program funded by the MCH Block Grant. Through a competitive process sixteen elementary schools within three Virginia school districts were selected to receive to support for the implementation and evaluation of the evidence-based Olweus Bullying Prevention Program over the next three years. Each school received all of the materials necessary for implementation and evaluation, program resources, and monthly consultation for 18 months. Certified Olweus Bullying Prevention Trainers were contracted to provide start-up training and technical assistance to each of the awarded schools. The program also continued to provide technical assistance and support to twenty-one schools throughout Virginia previously awarded implementation and evaluation support for the Olweus Bullying Prevention Program.

Collaboration with Virginia Departments of Criminal Justice Services and Education resulted in a statewide conference discussing the difference between bullying and sexual harassment and how to manage each appropriately in schools. Approximately 250 educators, administrators, school resource officers, and other youth-serving professionals attended.

Additional collaboration with the Department of Education resulted in plans to create web-based bullying prevention training modules to assist school divisions in satisfying legislative requirements to provide bullying prevention education to all school personnel.

Throughout the previous year, staff continued to provide technical assistance and consultation to organizations throughout the state. Direct consultation was provided to approximately 50 people through presentations and trainings made to school and community groups on bullying prevention strategies and the public health impact of bullying. A joint training was conducted with the VDH Violence Prevention Program about bullying prevention strategies and indicators of childhood trauma. Approximately 75 day care providers participated as a result of collaboration with the Department of Social Services Child Care Licensing Division.

b. Current Activities
Technical assistance and consultation to all schools awarded the Olweus Bullying Prevention Program is continued. VDH staff engages in quarterly communication with consultants to evaluate the progress made in each of the new 16 elementary schools implementing the Olweus Bullying Prevention Program during this first of three implementation years. Staff is currently preparing to provide these schools with access to the second year of electronic implementation and evaluation materials.

Collaboration with the Department of Education (DOE) is continuing with the development of web-based bullying prevention educational modules and comprehension checks using speaker presentations from the one day conference on bullying and sexual harassment conducted last year. Information will be available on the DOE website in Fall 2014 for school personnel statewide.

Staff continues to coordinate community engagement activities with youth serving organizations, parents and school professionals through site visits, community meetings, phone consultations, presentations, trainings and conferences. Specific examples include training to 50 Senior Connection mentors, presentations to 75 parents and onsite training to school staff due to the chronic youth and adult bullying of a child with disability. A plenary speech on bullying prevention

best practices was given at the Title IV 21st Century Community Learning Centers Conference, reaching approximately 150 educators.

c. Plan for the Coming Year

The Youth Bullying Prevention Project will continue to positively impact the lives of Virginia youth and facilitate the reduction of bullying through three primary initiatives: 1. coordination of the VDH Olweus Bullying Prevention Project (OBPP); 2. collaboration with the Virginia Department of Education (DOE) Office of Student Services in creating online interactive educational modules for teachers and staff; and 3. promotion of StopBullying.gov

The plan for the upcoming year includes:

•Continued support for the implementation of year 2 of the Olweus Bullying Prevention Project through: consultation for schools provided by certified trainers consistent with best practices in program implementation; consultation with school division coordinators, provided by VDH project coordinator; additional Olweus Bullying Questionnaire survey administrations to identify improvements and continued needs in each school; and technical assistance for training of new faculty and staff.

•Continued collaboration with the Virginia Department of Education (DOE) Office of Student Services in creating online interactive learning modules that may be accessed by stakeholders and other constituents across the Commonwealth to assist school divisions to meet State Board of Education requirements to educate staff in bullying prevention. The development of modules in bullying prevention will include the following topics: defining bullying and contrasting it with other forms of aggression; preventing bullying through effective policy implementation; intervening effectively when bullying occurs; reporting, investigating, and recording bullying incidents; and distinguishing between bullying and sexual harassment.

•Continued educational outreach efforts to include evidence-based trainings, technical assistance, public awareness activities, and resources provided to various organizations, schools, and community groups throughout Virginia.

•Promotion of StopBullying.gov, a free online resource promoting best practice resources in bullying prevention through the development of a StopBullying.gov curriculum training focused accessing resources and implementing research based strategies.

State Performance Measure 4: *The rate of childhood unintentional injury hospitalizations per 100,000 children ages 0-19.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2009**	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective			129	122.5	122.5
Annual Indicator	146.4	126.0	132.0	138.0	
Numerator	3046	2625	2750	2880	
Denominator	2080026	2083685	2083420	2087076	
Data Source	VA Hospital Discharge Data	VA Hospital Discharge Data	VA Hospital Discharge Data	VA Hospital Discharge Data	
Is the Data Provisional or Final?				Final	
	2014	**2015**	**2016**	**2017**	**2018**
Annual Performance Objective	120	120	117.5	117.5	115

Notes - 2013
Data for 2013 hospital discharges not yet available.

Notes - 2012
Data from 2012 hospital discharges

Notes - 2011
Data from 2011 hospital discharges

a. Last Year's Accomplishments
The Injury & Violence Prevention Program maintains an unintentional injury prevention program which focuses on the leading causes of injury morbidity and mortality among children and women of child-bearing age. The Program continued to host injury prevention content on its website, provide information on funding opportunities, new resources, and upcoming events through e-mail distribution lists, and information sharing meetings for injury stakeholder groups. Staff updated the Safe Students, Safe Schools in Virginia document with input from the Virginia Departments of Education and Criminal Justice Services to provide schools with a useful, up-to-date reference on school and student safety. The Program fulfilled requests for almost 120,000 individual pieces of educational material (brochures, videos on a variety of childhood injury topics) through the Injury & Violence Prevention Resource Center.

MCH Block Grant Funds supported much of the Program's focus on preventing various mechanisms of Traumatic Brain Injury. The Program developed an online training module on abusive head trauma (Shaken Baby Syndrome). Through a partnership with the Virginia Home Visiting Consortium this training was incorporated as an optional training module within the training requirements for early childhood home visiting services.

The Program expanded its work related to sports-related concussion prevention among youth athletes with the co-sponsorship of the Virginia Athletic Trainers' Association's annual meeting for 275 attendees with a special Youth Sports Safety Summit for 35 youth recreational league coaches and administrators. The Program also partnered with Arlington Public Schools to host two concussion education programs for all Arlington Public School coaches. Coaches were provided the knowledge to recognize signs/symptoms of concussion and remove athletes when appropriate, understand current standard-of-care regarding return-to-play, understand current medical knowledge of Chronic Traumatic Encephalopathy, and change current internal policies and practice habits to play sports more safely. The program was able to provide CDC created clipboard stickers for coaches that summarize signs/symptoms of concussion and other prevention information.

The Program has successfully collaborated with the Virginia Department of Education and schools across Virginia for several years to promote bicycle safety by modifying their physical education curriculum to include bicycle safety education that promotes injury prevention and traumatic brain injury prevention. To mitigate the level of risk, the Program developed an injury prevention training for health and physical education teachers to provide the foundation of injury prevention knowledge and skills needed for the implementation of a unit of on-the-bike instruction as part of the healthy and physical education curriculum. Approximately 60 K-12 health and physical education teachers completed the injury prevention training.

b. Current Activities
The Injury & Violence Prevention Program continues to coordinate statewide projects related to the prevention of high-priority childhood injury areas, to work with interagency and statewide committees on childhood injury prevention policy development, and to disseminate educational information and resources through its website, 1-800 number, e-mail distribution list-servs, and

workshops for injury prevention professionals. Staff continue to coordinate community engagement activities with various types of community and state level organizations through site visits, community meetings, phone consultations, presentations, trainings and conferences.

MCH funded staff have been working to update and enhance VOIRS, the Virginia Online Injury Reporting System, with 2012 injury-related death and hospitalization data. VOIRS allows users to create customized injury death and hospitalization data reports on various mechanisms and intents of injury by geographic and demographic variables.

c. Plan for the Coming Year

The Injury & Violence Prevention Program will continue to coordinate statewide projects related to the prevention of high-priority childhood injury areas, work with interagency and statewide committees on childhood injury prevention policy development, and disseminate educational information and resources through its website, 1-800 number, e-mail distribution list-servers, and workshops for injury prevention professionals.

Specific activities for the upcoming year will include efforts related to traumatic brain injury prevention, the promotion of safe sleeping environments for infants, and the prevention of poisonings related to prescription drug misuse and abuse.

Efforts related to the prevention of traumatic brain injury (TBI) for the coming year will continue to promote environmental modifications, policy implementation and outreach and education efforts to prevent concussion and other forms TBI among children. The project's work supports the early recognition of a head injury and proper treatment as well as the implementation of countermeasures that are proven to prevent and/or minimize the severity of brain injuries such as proper surfacing material on playgrounds, head protection and proper restraint use in motor vehicles. Planned activities include:

•Conducting a review of school policies and procedures to determine level of alignment with best practice procedures in concussion education, identification and management in the school setting.

•Providing trainings on the management of concussions in the K-12 student with a focus on cognitive and physical accommodations within the school setting critical to the prevention of negative long-term health implications.

•Providing Youth Sport Safety workshops for coaches and league administrators of non-interscholastic recreational youth sport leagues to provide education and support for policy change related to the recognition of signs/symptoms of concussion, removal of concussed athletes, and current standard-of-care related to return-to-play guidelines.

•Provide Bike Smart Basics trainings regionally for health and physical education K-12 teachers.

VDH has acknowledged the substantial impact that safe sleep environments have in the prevention of infant mortality with the prioritization of this issue in the VDH Thriving Infants Strategic Plan. Injury and Violence Prevention Program staff will lead a workgroup to develop a detailed implementation plan based on recommendations in the Strategic Plan.

The Injury & Violence Prevention Program will continue to partner with community-based drug free organizations to provide trainings for health care providers regarding prescribing controlled substances. Plans for the coming year include providing trainings to healthcare providers with a special emphasis on Neontal Abstinence Syndrome. The training audience will include specialized obstetrics, neonatal and pediatric providers.

State Performance Measure 5: *Percent of low income children (ages 0-5) with dental caries.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2009	2010	2011	2012	2013
Annual Performance Objective	12.2	12.1	12	18	17
Annual Indicator	17.8	19.4	18.4	17.2	15.4
Numerator	2327	2498	2094	1823	1796
Denominator	13091	12890	11407	10599	11670
Data Source	Head Start Data	Head Start Data	Head Start Data	Head Start Data	Head Start Data
Is the Data Provisional or Final?				Final	Final
	2014	**2015**	**2016**	**2017**	**2018**
Annual Performance Objective	16.8	16.5	16.3	16	15.8

Notes - 2013
FY13 Head Start Data; State FY 7/1/12-6/30/13

Notes - 2012
FY12 Head Start Data; State FY 7/1/11-6/30/12

Notes - 2011
FY11 Head Start Data; State FY 7/1/10-6/30/11

a. Last Year's Accomplishments
The Dental Health Program (DHP) provided local health department dentists with assistance in recruiting and orienting new staff, collecting patient data, and workforce development. Additionally, DHP staff conducted quality assurance reviews for local health department dental clinics. Local health department dental clinics provided 27,688 visits for individuals and 107,238 clinical services valued at more than $8.7 million during FY 2013. Approximately 71% of all dental visits were for school-aged children and more than 8,500 dental sealants were placed. More than 3244 dental visits were provided for children ages 0-4 years.

Bright Smiles for Babies (BSB), the fluoride varnish program for children five and under, maintained services in multiple health districts. In FY 2013, approximately 6800 screenings and 6400 fluoride varnish applications were provided for children enrolled in the Special Supplemental Nutrition Program for Women, Infants and Children (WIC) programs; and 660 screenings and varnish applications were provided for children in Early Head Start (EHS) Programs. Individual risk-based counseling was also provided to 7613 parents of WIC-enrolled children regarding daily oral hygiene, nutrition, feeding practices, fluoride, and the importance of primary teeth. A total of 4489 children were referred to a dental home.

BSB program data is collected by 4 HRSA Workforce grant-funded hygienists in 4 health districts to collect parent knowledge and child disease data.

BSB exhibits were held at three professional conferences, targeting nurse practitioners, physician assistants and physicians. Staff continued to train early child, medical, and dental providers in public and private settings. 144 early child providers were trained in various venues regarding the importance of early child oral health. Fifteen private medical offices and two new health districts were trained to provide fluoride varnish via staff nurses.
As reported last year, the Robert Wood Johnson Foundation (RWJF) visited the BSB program in October 2012 and reported that the program is a strong candidate for a full formal evaluation. RWJF subsequently published a synthesis report in October 2013, noting the Bright Smiles for Babies is one of seven nationwide programs with a workforce model significantly increasing access to care, and ready for ‘outcome-focused' evaluation.

Two continuing education trainings (Chesapeake and Kilmarnock) were provided to 38 dentists, hygienists and auxiliary staff regarding the dental care of children with special health care needs (CSHCN) and very young children. The hands-on portion of the training allowed providers to treat 38 CSHCN as part of the continuing education course. The dental home visiting/ family educator trainings continued and were provided to 48 family educators in Virginia Beach and Bristol, Virginia. This training included an overview of oral health and age appropriate key messages for high-risk child populations, including CSHCN. Partnerships with the Bristol Care Connection for Children pediatric medical specialty clinics allowed hygienists to provide CSHCN 257 oral screenings, 272 fluoride varnish applications, anticipatory guidance for 270 parents of CSHCN, and 175 referrals to a dentist. Staff also assisted with the 2013 Connections Resource Fair for families and professionals working with CSHCN and provided oral screenings, fluoride varnish, education and referrals for 28 CSHCN during the event.

VDH continues to work with the Department of Medical Assistance Services (DMAS) serving on the DMAS Advisory Committee, as well as a 'mini' data committee along with Dentaquest to measure BSB program impact on early dental visits. DHP also serves on the state Head Start Health Advisory Committee, the Virginia Infant Mortality Workgroup and implementation teams, and multiple Virginia Oral Health Coalition (VAOHC) committees.

b. Current Activities

Health department dental clinics continued to provide varnish applications for children < 4 years old. Over 3400 screenings/ varnish applications were provided to children in WIC and EHS. An online training on oral health and pregnant/ preconceptual women was completed by more than 300 nurses. BSB trainings have been provided for 6 private physician offices and 3 VDH districts, in addition to local component dental hygienists and hygiene students.

New partnerships were formed with the Medical Society of Virginia and Medicaid Managed Care to promote awareness and implementation of the BSB program to Medicaid providers. DHP is also collaborating with DSS to reach early child providers. The Early Dental Home Initiative has been successful and has expanded to include a data committee to determine the impact of BSB on dental visits for young children. DHP activities also support the efforts of Virginia Medicaid's Oral Health Learning Collaborative grant. Six trainings are scheduled for licensed day care workers to provide resources for the families that they serve.

85 dental professionals were trained on dental care for CSHCN and very young children; the hands-on portion of the training allowed providers to treat 64 patients. VDH has provided CSHCN with 119 oral screenings, 118 varnish applications, 82 dental referrals and oral health education for 135 parents of CSHCN. Oral health education was provided to home visitors and 35 family educators statewide.

c. Plan for the Coming Year

VDH will work to increase the current level of services provided through the BSB program to WIC and EHS children through all potential funding sources and program models. VDH is exploring the option of WIC-supported public health dental hygienists as a workforce model to increase direct access to a dental hygienist for very young, high risk children. Of Virginia's 35 health districts, all but two districts have implemented the BSB program utilizing one or more models. We will continue to promote the program via the VaOHC partnerships and reaching out to the Medicaid MCOs. The licensed day care providers will be targeted for another round of training in the fall of 2014, in addition to other DSS-related provider networks. The National Center on Health's new Head Start Oral Health Form will be discussed with the Virginia Head Start Association's Executive Director to determine how to best optimize the use of this form for dental

disease data gathering. Meetings are planned for this summer.

VDH will provide ongoing consultation and training, as needed. Oral health training for home visitors, family support workers, and health educators will continue throughout the state to ensure that information is disseminated to families of CSHCN and very young children served by home visiting and other family education programs. Currently, two courses are planned in April 2014 in Abingdon and Wytheville.

Through collaboration with the Virginia Dental Association Foundation (VDAF) and continued funding, the DHP hopes to continue providing the continuing education courses for dental professionals across the state to encourage care of CSHCN and very young children. The goal is to provide three more courses over the course of FY15.

The DHP will continue to partner and collaborate with Care Connection for Children, Child Development Clinics, hospitals, the Virginia Department of Education, and CSHCN parent/professional organizations to disseminate oral health education, increase application of fluoride varnish for these high risk children, and increase dental visits by age one. VDH will continue collaboration with Virginia Commonwealth University (VCU) School of Dentistry to increase opportunities for students and residents to work with CSHCN during their dental training. VCU has also offered to continue including pediatric dental residents as assistant clinical instructors for future continuing education courses for dentists and hygienists planned with VDAF.

State Performance Measure 6: *Percent of low income third grade children with dental caries.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2009**	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective			20	15	12
Annual Indicator	25.3	15.4	12.4	12.4	
Numerator	6649	1207	3756	3756	
Denominator	26315	7837	30337	30337	
Data Source	Virginia Free Lunch Program	Virginia Free Lunch Program	Virginia Free Lunch Program	Virginia Free Lunch Program	
Is the Data Provisional or Final?				Provisional	Provisional
	2014	**2015**	**2016**	**2017**	**2018**
Annual Performance Objective	11.5	11	10.5	10	10

Notes - 2013
Data for 2013 not yet available.

Notes - 2012
Data for 2012 from then Virginia Free & Reduced Lunch Program

Notes - 2011
Data for 2011 from then Virginia Free & Reduced Lunch Program

a. Last Year's Accomplishments
Local health department dental clinics provided 27,688 visits for individuals and 107,238 clinical services valued at more than $8.7 million during FY 2013. Approximately 71% of all dental visits were for school-aged children and more than 8,500 dental sealants were placed. The Dental Health Program (DHP) provided support to the local health department dental clinics through conducting a quality assurance program, assisting with recruitments, collecting patient services data, providing workforce development, and orienting new dental staff. On-site quality assurance clinic reviews were completed for two dental clinics. One district received assistance in recruitment of new dental staff. Eight Health Districts used Title V funds to provide dental services to school age and preschool children to include education and dental varnish placement, as well as sealants.

In 2013, CDC indicated the population on community (public) water systems receiving fluoridation as 6,180,848 or 95.86%. VDH maintains databases detailing statewide water systems data related to fluoridation levels and reports details of all 1,325 community water systems and the data from monthly fluoridation operational reports for the 143 systems providing fluoridation in Virginia to CDC. In 2013, 19 contracts for grant projects were completed serving 120,000 citizens. Two broad-based population grant projects to provide split sample test kits to the Southwest water treatment plants were completed. Sixty-three waterworks operators and two engineers completed training on community water fluoridation. Concerted efforts to maintain fluoridation were successful via technical and grant assistance serving over 34,000 people; detailed technical support was provided to large communities combining to serve over 1 million people.

Education programs regarding oral hygiene, nutrition, and fluorides were conducted in FY13 for 13,875 school-aged children, teachers, and school nurses. Programs aimed at improving the oral health of children with special health care needs (CSHCN) of all ages, including training for health professionals, lay health workers, and family members were continued in FY13.

b. Current Activities
The DHP supports local dental programs in recruitments, orientations, and technical assistance and in the clinical supervision of community-based preventive services dental hygiene teams. Quality assurance reviews were completed for 8 dental hygiene staffed sites. For the purpose of internal alignment with an evolving mission emphasizing more preventive and population-based programs, VDH initiated a restructuring of dental clinical services from a clinic treatment model to a community-based prevention model. The DHP has led a group of stakeholders to plan the transition of clinical programs to this new model.

Virginia has continued to maintain and meet the 2020 Healthy People objective for the percentage of the population with access to fluoridated water. The DHP monitored 143 water systems serving more than six million people for compliance with fluoridation standards. Contracts for grant funding for 10 communities to upgrade equipment to maintain optimal fluoridation have been written. Planning for two fluoridation training courses is underway. Technical assistance on fluoridation topics is provided to several localities and individuals and is on-going.

The DHP elected to continue the school-based fluoride mouthrinse program in three Health Districts in FY14. More than 3,500 elementary children continue to participate in the mouthrinse program. The hygienists in these Districts provide program training for children and technical assistance to school staff.

c. Plan for the Coming Year
The DHP will continue to focus on population-based activities including oral health education, fluoride rinse, topical fluoride applications, sealant application and promotion and community water fluoridation to reduce the disease burden of tooth decay.

An increasing emphasis on prevention services and population-based programs will be fully implemented in FY15 with expansion of dental hygienists deployed in the Districts. Their responsibilities will include direct preventive services in schools and community settings as well as education, oral health promotion and linking of identified children with dental caries to sources of care in the community. Placement of sealants and fluoride varnishes on the teeth of high risk children will be a priority.

Continuation is anticipated of a Centers for Disease Control and Prevention "State Based Oral Disease Prevention Program" grant, awarded in FY 12 and 13, to establish, strengthen, and enhance the infrastructure and capacity of states to plan, implement, and evaluate population based oral disease prevention and promotion programs. A HRSA Workforce grant also supports oral disease prevention efforts in four communities. These resources will be used synergistically with existing programs to maximize the targeted efforts aimed at identifying priority populations and reducing childhood decay.

Community Water Fluoridation data management activities, education, and grant funding for fluoridation projects will continue in FY15.

A statewide basic screening survey of third graders is planned for fall of 2014. This survey will include a parent questionnaire and an open mouth screening of over 9,000 children chosen as a representative sample of the Commonwealth.

State Performance Measure 7: *Percent of women with a live birth who went to a dentist during pregnancy.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2009**	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective			50	50	45
Annual Indicator	40.0	48.8	40.1		
Numerator	40109	47965	38709		
Denominator	100226	98389	96483		
Data Source	VA PRAMS	VA PRAMS	VA PRAMS		
Is the Data Provisional or Final?				Provisional	Provisional
	2014	**2015**	**2016**	**2017**	**2018**
Annual Performance Objective	47.5	50	52.5	55	55

Notes - 2013
Weighted 2013 VA PRAMS data not yet available.

Notes - 2012
Weighted 2012 VA PRAMS data not yet available.

Notes - 2011
Weighted 2010 VA PRAMS Data

a. Last Year's Accomplishments
The Dental Health Program (DHP) was identified as a key stakeholder in Virginia's Infant Mortality Reduction Plan. Our staff participated in the strategic planning process, resulting in a preconception objective specific to accessing oral health services. DHP staff continued to provide direct education services utilizing dental hygienists in the Bright Smiles for Babies Program (BSB) in the Special Supplemental Nutrition Program for Women, Infants and Children (WIC) clinics in local health departments. The hygienists, while providing services for WIC-enrolled children, sought out WIC-enrolled women for oral health education, oral health educational materials, a toothbrush, toothpaste, and dental referrals during their WIC visits. Education for pregnant women focuses on the importance of professional dental care during pregnancy and making appropriate referrals to women without a dental home. In FY 2013, 481 pregnant women were provided with individual education sessions from a dental hygienist during the program.

Multiple oral health trainings, including pregnancy-related oral health topics, were provided to 144 early child providers and 50 lay health workers, including Head Start, Early Head Start, and CHIP of Virginia, and other lay workers and home visiting staff. The DHP also worked with the new Virginia Text4baby program and customized 2 oral health text messages for pregnant women and new mothers in Virginia.

Through collaboration with the Virginia Oral Health Coalition's (VAOHC) Medical and Dental Collaboration Initiative, DHP continued to identify new partners and attend meetings and summits to promote oral health for pregnant women.

b. Current Activities
The DHP piloted education efforts for health department clients, including maternal and family planning clinics. The pilots were carried out in 4 health districts, concluding that the WIC model of accessing pregnant women is the most advantageous due to local level volume. DHP also expanded services to WIC-enrolled pregnant women to include oral screenings, education and referrals. Training was provided to DHP dental hygienists, with expanded services beginning in September 2013; 305 pregnant women received oral health education, 99 received oral screenings, and 121 received a dental referral. Trainings on the importance of dental care during pregnancy were provided to 63 early child staff and 50 lay health workers. WIC Health Bites continues to show oral health education messages accessed by WIC-enrolled women. DHP developed and implemented a course, "Oral Health and Pregnancy", which has been completed by approximately 300 VDH public health nurses. DHP is currently active in Virginia's Infant Mortality Work Plan, with plans to participate in the Dental Health Implementation team. The DHP submitted 2 Virginia-customized messages for the Text4baby service.

DHP continues to identify new partners through the VAOHC Medical and Dental Collaboration Initiative. DHP staffs plan to work with the VAOHC to develop and implement a program to increase awareness among dental and medical providers of the importance of optimal oral health during pregnancy.

c. Plan for the Coming Year
VDH will continue to maintain and expand direct and indirect education services. A brief survey regarding oral health knowledge and behaviors and specifically addressing dental visits during pregnancy will be considered as a part of the expanded WIC services. DHP will also work with VAOHC to reach non-VDH maternal providers for oral health training opportunities. We will continue to work on the VDH Thriving Infants Strategic Plan implementation teams, including Text4baby efforts and the Dental Health Implementation Team. Continued collaboration with the VAOHC, participating in the Medical and Dental Collaboration Initiative to support training

obstetricians regarding oral health recommendations for pregnant women is also planned for the coming year.

State Performance Measure 8: *Percent of children eligible for WIC that are enrolled in WIC, ages 0 to 5.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2009**	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective			80	75	77
Annual Indicator	69.3	75.8	74.1	76.5	76.7
Numerator	115089	128661	125441	127132	126084
Denominator	166189	169638	169394	166208	164283
Data Source	WIC Program	WIC Program Data	WIC Program Data	WIC Program Data	WIC Program Data
Is the Data Provisional or Final?				Final	Final
	2014	**2015**	**2016**	**2017**	**2018**
Annual Performance Objective	78	78.5	79	79.5	80

Notes - 2012
Data from the WIC "Annual Potential Eligible" projections report, 2012.

Notes - 2011
Data from the WIC "Annual Potential Eligible" projections report, 2011.

a. Last Year's Accomplishments
In FY 2013, the Virginia WIC Program served a monthly average of participants statewide, an average of per month were children. Thirty five local health districts provided direct services to WIC participants, and the Division of Community Nutrition (DCN) continued to work with other state partners to strengthen the program. These partners include the State WIC Advisory Committee, the Virginia Chapter of the American Academy of Pediatrics, the Virginia Breastfeeding Advisory Committee, the Commissioner's Workgroup on Obesity Prevention and Control, the Commissioner's Infant Mortality Workgroup, the Virginia Department of Medical Assistance Services, Virginia Cooperative Extension, and the United States Department of Agriculture.

DCN is collaborating with the Child and Adult Care Food Program (CACFP) to increase WIC participation among children enrolled in Head Start. By working with Head Start programs participating in CACFP, WIC will have the opportunity to reach eligible children and families who may not currently be enrolled in the program. Through program outreach, education and potentially service integration, the enrollment rates for children in the Virginia WIC Program could increase. DCN houses both the WIC and CACFP which will facilitate communication and coordination between programs.

A partnership with the Virginia Community Healthcare Association (VCHA) is also anticipated to continue. The VCHA is the state association for Federally Qualified Health Centers (FQHCs); these health centers are located in medically underserved areas. By offering WIC clinical services in FQHCs, it is anticipated that the number of WIC participants, including children, will

increase. Efforts to begin incorporating WIC clinical services into the health centers will be contingent upon availability of federal funding. The process would begin with DCN conducting a feasibility study that will guide the integration of services.

b. Current Activities

In November 2013, DCN implemented the pilot test in the Crater Health District for the Crossroads and e-WIC systems. The Crater Health District provided a myriad of options for the program to include urban, suburban, rural communities, as well as, a military installation. In addition, the remaining thirty-four health district have implemented the new systems in the winter and spring of 2014. These systems facilitated the discontinuation of paper food benefits and the progression to electronic benefits. These benefits are aggregated at the family level to integrate the mother-baby dyad for infant feeding and allows for tailoring of the food packages.

DCN continues to collaborate with the Child and Adult Care Food Program (CACFP) to increase WIC participation among children enrolled in Head Start. By working with Head Start programs participating in CACFP, WIC will have the opportunity to reach eligible children and families who may not currently be enrolled in the program. Through program outreach, education and potentially service integration, the enrollment rates for children in the Virginia WIC Program could increase. DCN houses both the WIC and CACFP which facilitates communication and coordination between both programs.

c. Plan for the Coming Year

In February 2014, The US Department of Agriculture released the Final WIC Food Package Rules. DCN will implement the increase of Cash Value Benefits for children from six dollars to eight dollars. This change will occur on June 1, 2014. DCN will implement all of the required provisions-split tender for fruits and vegetables; offering whole grain rolls; and allowing the determination of need for milk substitutes. In addition, DCN will exercise many of the state options for the Food Package Rule, which may include fresh fruits and vegetable for infants in lieu of infant foods.

State Performance Measure 9: *Percent of eligible children in daycares that participate in the Child and Adult Care Food Program (CACFP).*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2009**	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective			25	27.5	40
Annual Indicator		16.5	25.7	37.0	25.8
Numerator		59196	69887	103447	70410
Denominator		358008	271422	279386	272386
Data Source		CACFP, VA Dept of Social	CACFP, VA Dept of Social	CACFP, VA Dept of Social	CACFP, VA Dept of Social

		Services	Services	Services	Services
Is the Data Provisional or Final?				Final	Final
	2014	**2015**	**2016**	**2017**	**2018**
Annual Performance Objective	42.5	45	47.5	50	50

Notes - 2013
Numerator is the number of children ages 0-12 years in daycares that participated in the Child and Adult Care Food Program during 2013.

Denominator is the total licensed capacity for child daycare in Virginia during 2013. Data provided by the Virginia Department of Social Services.

Notes - 2012
Numerator is the number of children ages 0-12 years in daycares that participated in the Child and Adult Care Food Program during 2012.

Denominator is the total licensed capacity for child daycare in Virginia during 2012. Data provided by the Virginia Department of Social Services.

Notes - 2011
Numerator is the number of children ages 0-12 years in daycares that participated in the Child and Adult Care Food Program during 2011.

Denominator is the total licensed capacity for child daycare in Virginia during 2011. Data provided by the Virginia Department of Social Services.

a. Last Year's Accomplishments
CACFP provides year-round federal funding to eligible child care, family day care, Head Start, at-risk after school care, emergency shelter, and adult care centers to provide nutritious meals and snacks to lower income participants in these care programs.

Enrollment in the CACFP decreased in 2012 with an average daily participation rate of 53,637. This compares to 63,540 for FY 2011 (-8.44%). Applications were reviewed and approved for 13 Family Day Care Sponsors for 2,524 Family Day Care Homes. Applications were approved for 402 Child Care Sponsors for 1,881 sites. During the fiscal year the Division of Community Nutrition (DCN) conducted reviews on 145 Day Care Sponsors and 113 day care sites and 5 Family Day Home Sponsors and 68 homes to ensure compliance with federal and state policies and regulations.

A significant challenge for FY 2011 was the President's signing of the Healthy and Hungry Free Kids Act in January, 2011. New policies that provided an additional supper option in the afterschool program increased the number of meals served to at-risk children.

b. Current Activities
DCN continues to provide monitoring, training, and technical assistance to CACFP providers as well as policy development and implementation. Technical assistance is provided by the Special Nutrition Programs (SNP) team though telephone and written correspondence and on-site visits. Currently DCN has 13 Family Day Care Sponsors with 2,407 sites and 372 CACFP Sponsors with 1,464 sites. Approximately 145 reviews are scheduled for FY 2013. DCN is developing and hosting training and reviews for newly approved institutions. In addition, there will be annual training developed for institutions currently participating in the program.

The Healthy, Hunger Free Kids Act of 2010 necessitated numerous policy and procedure changes which DCN has implemented and will continue to implement into FY 2014. Two major policy changes in the year 2013 will be the elimination of whole and 2% milk served to children over the age of two.

DCN has also begun to establish relationships with many state partners including Virginia Department of Education, Virginia Department of Social Services, Office of Early Childhood Development, Virginia Family Day Care Sponsor's Association, Virginia Head Start Association, Virginia Head Start Collaboration Office, Virginia Foundation for Healthy Youth, and Virginia School Nutrition Association.

The development of a new online claim processing system for CACFP and the Summer Food Service Program is under development.

c. Plan for the Coming Year

DCN will continue to administer the CACFP and strengthen relationships with internal and external partners. In an effort to strengthen the quality of child day care centers and homes participating in the program, DCN plans to work on developing nutrition and physical activity guidance for providers. This will be done in conjunction with state partners including the VDH Obesity Prevention Team, the Virginia Department of Social Services, and the Office of Early Childhood Development. DCN also has a goal of developing online training modules for participating CACFP institutions to make training more accessible.

In 2014, CACFP will have a new meal pattern that increases the amounts of fruit and vegetables, increases whole grains, and decreases the amounts of salt, sugar and added fats.

State Performance Measure 10: *Percent of eligible children participating in the Summer Food Service Program (SFSP).*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2009**	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective			15	12	14
Annual Indicator	11.4	10.8	11.8	13.8	11.7
Numerator	51798	50767	57905	67401	60197
Denominator	454310	469472	491946	489636	512752
Data Source	SFSP, VA Dept of Education	SFSP, VA Dept of Education	SFSP, VA Dept of Education	SFSP, VA Dept of Education	SFSP, VA Dept of Education
Is the Data Provisional or Final?				Final	Final
	2014	**2015**	**2016**	**2017**	**2018**
Annual Performance Objective	14.5	15	15.5	16	16.5

Notes - 2012
Numerator data from the 2012 Summer Food Service Program.

Denominator data provided by the Virginia Department of Education.

Notes - 2011
Numerator data from the 2011 Summer Food Service Program.

Denominator data provided by the Virginia Department of Education.

a. Last Year's Accomplishments
SFSP provides federal funding to eligible sponsor organizations to provide meals and snacks to lower income children during the summer months when school is not in session. SFSP sponsor organizations can be a school, camp, governmental entity, private non-profit organization, or a college participating in the National Youth Sports Program.

Summer of 2012 resulted in increased compliance procedures for the SFSP sponsors. Processes and procedures were developed to ensure that all regulations are met. VDH is worked with the Environmental Health Staff in the districts to increase the number of food safety inspections at each summer site. VDH has a toll free number for sponsors, prospective sponsors and the public seeking information and/or technical assistance.

The number of sponsors for 2012 was 120, the number of sites was 1550, and the average daily attendance for children receiving meals was 58,051 across the Commonwealth.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Provide meal and operational reimbursements and administrative oversight to daycares participating in SFSP.	X			
2. Review and make recommendations regarding proposed legislation or policies affecting the Virginia SFSP.				X
3. Perform outreach with partners at DOE, DSS, VDACS, and the Virginia Cooperative Extension to inform the families of eligible children about program availability.			X	
4. Collaborate with partners to ensure that SFSP sites and sponsors participate in the program and offer meals in areas with highest unmet need.			X	
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
The SNP team continues to strengthen their relationships with agency, state and community partners including: VDH Office of Environmental Health, Virginia Department of Education (DOE), Virginia Department of Social Services (DSS), Virginia Department of Agriculture and Consumer Services (VDACS), Virginia Cooperative Extension (VCE), The Virginia Food Banks, and Share our Strength.

Planning is underway for the 2013 summer program. The planning includes surveying last year's

sponsors to determine if they plan to participate and analyzing school data regarding the free-and-reduced price meals to determine areas of potential need and develop targeted outreach.

A new application for the 2013 program has been developed and to date approximately160 applications have been sent out.

USDA identified Virginia as a Strike Force State and is helping VDH partner with the Virginia Department of Education to increase summer feeding in the areas of need. VDH is also partnering with Share our Strength and the Virginia Department of Social Services to develop a website and link to the 2-1-1 system for parents and children to identify the SFSP site closest to them. Parents can text their zip code to the Share our Strength number and the SFSP sites closest to them are sent back in the form of a text message.

c. Plan for the Coming Year

DCN will continue to strengthen their partnership and communication with other VDH departments and outside agencies who will serve as partners for SFSP; this includes the VDH Office of Environmental Health, Virginia Department of Education, Virginia Department of Social Services, Virginia Department of Agriculture and Consumer Services, and Virginia Cooperative Extension.

Outreach efforts to reach areas with the highest levels of unmet need will continue for FY 2014; targeted areas will be defined in the FY 2013 Management and Administration Plan. These efforts will be directed toward reaching counties and cities with the highest percentages of eligibility for free-and-reduced-price meals and the highest unmet needs as evidenced by the level of SFSP participation. Publication of SFSP availability will continue to occur through the Virginia Department of Social Services 2-1-1 system as well as WIC clinics, and by working with Virginia Department of Education to disseminate printed or electronic materials to families of school children prior to the end of the school year. We will ask SFSP sponsors to have their sponsors post signs showing meal location, dates and times at a location that is visible from the street. We will share with the sponsors SFSP practices that other states have found successful for increasing participation. We will also present information about SFSP at the Virginia Faith-Based & Neighborhood Partnership meeting in February. Share our Strength will also develop a website that will help parents and the community locate SFSP sites.

DCN staff will continue responding to inquiries, identifying and contacting prospective sponsors, and assisting current sponsors in efforts to expand their participation or number of sites.

The development of a new online claim processing system for SFSP and CACFP will occur in FY 2014 simultaneously, as the two programs will share the system. A new claims processing system will increase program efficiencies both at the state and provider levels.

E. Health Status Indicators

Health Status Indicators 01A: *The percent of live births weighing less than 2,500 grams.*

Health Status Indicators Forms for HSI 01A - Multi-Year Data

Annual Objective and Performance Data	2009	2010	2011	2012	2013
Annual Indicator	8.2	8.1	8.5	8.0	7.8

Numerator	8656	8338	8065	8240	7277
Denominator	104979	102934	95334	102812	93374
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2013
2013 provisional birth certificate data.

Notes - 2012
2012 birth certificate data.

Notes - 2011
2011 birth certificate data.

Narrative:
The first MCH priority is to reduce infant mortality in the state. Since birth weight is an important determinant of infant health and survival, Virginia utilizes this health status indicator to as a basis for developing plans and resource allocation aimed at reducing the number of infants born weighing less than 2500 grams as well as infant mortality rates.

Virginia's overall infant mortality rate during 2011 was 6.7, falling short of meeting the Healthy People 2020 goal of 6.0 infant deaths per 1,000 live births. Virginia has made great strides in reducing overall infant mortality in recent years, but there are still disparities. The rate of infant death for Hispanic infants of any race (6.7 per 1,000 live births) did not meet the Healthy People goal of 5.0 infant deaths per 1,000 live births in 2011; White non-Hispanic infants did meet the goal with a rate of 5.2 per 1,000 live births. However, non-Hispanic black infants were nearly three times more likely to die within the first year of life (12.8 per 1,000 live births).

Despite a slight decline in the percent of low birth weight (LBW) in recent years, trend analyses of HSI 01A shows a statistically significant increase in the percent of infants born weighing less than 2500 grams since 1999. This trend was noticeable beginning in 2010. In 2011, 8.5% of all Virginia births were low birth weight, up from 8.1% in 2010, and 8.2% in 2009. The racial/ethnic disparity in LBW infants continued in 2011. Of all black non-Hispanic infants, 12.2% were low birth weight. For white non-Hispanic infants, 6.6% were low birth weight. Historically the percent of Hispanic infants of any race had the lowest percent of low birth weight, in 2011, 6.1% of Hispanic infants of any race were born weighing less than 2,500 grams, down from 8.1% in 2010.

The Commissioner's Workgroup on Infant Mortality (HCIMWG), created in 2008, reflects the VDH's commitment to addressing Virginia's infant mortality rate. The focus of the workgroup during the last year has been to develop the five-year VDH Thriving Infants Strategic Plan. Currently implementation teams are developing strategies to address the plan's recommendations.

Virginia was selected to participate in the National Governor's Association (NGA) Center for Best Practices' Learning Network on Improving Birth Outcomes. The December meeting addressed the racial/ethnic disparity that exists in infant mortality. One of the major goals of the IMRSP includes strategies to decrease the incidence of preterm and low weight births as a way to reduce infant mortality. Since tobacco use, obesity and poor nutrition are associated with preterm and low weight birth, implementation teams to promote the utilization of the Virginia Quitline and to increase utilization of the WIC program are being established.

Health Status Indicators 01B: *The percent of live singleton births weighing less than 2,500 grams.*

Health Status Indicators Forms for HSI 01B - Multi-Year Data

Annual Objective and Performance Data	**2009**	**2010**	**2011**	**2012**	**2013**
Annual Indicator	6.4	6.3	6.1	6.2	6.0
Numerator	6449	6260	6000	6115	5411
Denominator	101070	99159	98810	99016	89997
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2013
2013 provisional birth certificate data.

Notes - 2012
2012 birth certificate data.

Notes - 2011
2011 birth certificate data.

Narrative:
The singleton low birth weight health status indicator is one of Virginia's best indicators for progress in reducing the percent of infants born weighing less than 2,500 grams. As OFHS moves towards incorporating a life course perspective, data have been used to identify methods to improve preconception health behaviors, increase access and utilization of preconception health services, and help women identify and manage chronic conditions before pregnancy. Preconception health is a critical part of wellness for women as well as an important factor for improving pregnancy outcomes. The PRAMS survey is the primary source of data about the attitudes, behaviors, and experiences of women before they become pregnant.

A reduction in the number of low weight births in the singleton births category would make a significant reduction in the percent of infants born with low birth weight in Virginia. Of all live singleton births in 2012, 6.1% of the infants weighed less than 2,500 grams, and the racial/ethnic disparities remained in 2012. The percent of black non-Hispanic LBW singleton births was more than twice that of white non-Hispanic LBW singleton births (10.2% vs. 4.7%), while the percent of Hispanic LBW singleton births was 5.0%.

Mutlifetal pregnancies are associated with early delivery and subsequent low birth weight. It is important to examine the difference between the total number versus singleton only low weight births because the clinical reasons are quite different. The psychosocial and social determinants of health factors are more critical to a discussion regarding low birth weight births in the total population. Infertility treatments and maternal age are more likely contributing factors to the incidence of multiple pregnancy and subsequent low weight births.

Health Status Indicators 04A: *The rate per 100,000 of all nonfatal injuries among children aged 14 years and younger.*

Health Status Indicators Forms for HSI 04A - Multi-Year Data

Annual Objective and Performance Data	**2009**	**2010**	**2011**	**2012**	**2013**
Annual Indicator	161.6	149.8	157.5	124.8	129.6
Numerator	2485	2296	2424	1929	
Denominator	1537640	1532720	1539145	1545288	
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2013
2013 data not yet available. Entry is an estimate based on trend.

Relevant changes in Virginia law: July 1, 2010: All children between their 8th and 18th birthday must be properly restrained by a child restraint system or a safety belt. Violations will result in a $50 fine.

Notes - 2012
Data from Virginia hospitalization discharge data and NCHS population estimates, 2012.

Relevant changes in Virginia law: July 1, 2010: All children between their 8th and 18th birthday must be properly restrained by a child restraint system or a safety belt. Violations will result in a $50 fine.

Notes - 2011
Data from Virginia hospitalization discharge data and NCHS population estimates, 2011.

Relevant changes in Virginia law: July 1, 2010: All children between their 8th and 18th birthday must be properly restrained by a child restraint system or a safety belt. Violations will result in a $50 fine.

Narrative:
Since 1999 the rate of nonfatal injuries in children aged 14 years and younger has significantly decreased from 225.7 per 100,000 children aged 14 years and younger to 142.1 in 2012. A change in Virginia's child restraint law in 2007 has contributed to the decrease in nonfatal injuries and motor vehicle deaths. In 2007 the age requirement for children to be secured in an approved safety seat while riding in a vehicle increased from five to eight years old. Hispanic children had the lowest rate of non-fatal injury at 88.5 and black non-Hispanic children had the highest rate at 178.4/ 100,000 compared to white non-Hispanic children at 154.1.

The VDH Injury and Violence Prevention Program prevents injuries to children through public information, training, community education and events, and support for community coalitions. The unintentional injury prevention program focuses on the prevention of the leading causes of fatal and non-fatal unintentional injuries in Virginia by examining injury patterns and by identifying groups at high risk and potentially modifiable factors. The program focuses available resources on the prevention of unintentional injuries determined to be the leading causes based on

available Virginia injury data. Resources are also focused on those causes that have an enormous impact on audiences that can be effectively targeted with information and countermeasures that will result in the desired behavior change. The program utilizes prevention strategies and related activities at both the state and local levels to support the accomplishment of goals in the areas of child passenger safety, traumatic brain injury, safe sleep/suffocation prevention and general injury prevention outreach, education and policy. These strategies include raising awareness of the scope of the injury problem through sharing of data, information and resources, presentations, trainings and exhibits, and collaborative projects; increasing the number of state and local agencies, organizations and groups committed to and working on injury prevention through consultation and technical assistance, leadership of a state injury planning group, coordination of local prevnetion projects and dissemination of proven safety devices and partnerships; and policy development.

Health Status Indicators 04B: *The rate per 100,000 of nonfatal injuries due to motor vehicle crashes among children aged 14 years and younger.*

Health Status Indicators Forms for HSI 04B - Multi-Year Data

Annual Objective and Performance Data	**2009**	**2010**	**2011**	**2012**	**2013**
Annual Indicator	11.2	9.2	10.4	10.5	12.8
Numerator	172	141	160	163	
Denominator	1537640	1532720	1539145	1545288	
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2013
2013 data not yet available. Entry is an estimate based on trend.

Notes - 2012
Data from Virginia hospitalization discharge data and NCHS population estimates, 2012.

Notes - 2011
Data from Virginia hospitalization discharge data and NCHS population estimates, 2011.

Narrative:
Since 1999 the rate of nonfatal injuries due to motor vehicle crashes among children aged 14 years and younger has significantly decreased. In 2012 the rate was 8.1 per 100,000 children in this age range. Black non-Hispanic children had the highest rate of nonfatal injuries (12.4) and Hispanic children had the lowest rate (2.7). About 50% of all deaths of children aged 14 years and younger are due to injuries, and around 80% of these are from motor vehicle crashes. Injuries are the leading cause of mortality in this age group and they are the most significant health problems affecting the Nation's children.

The Injury and Violence Prevention Program coordinates a child passenger safety program that promotes proper safety seat restraint use for children from birth until they transition to the vehicle safety belt; increases risk perception and correct usage of child restraints among parents and care givers through outreach and education; provides proper installation education through

community safety seat check stations and events; and addresses financial barriers that prohibit access to safety seats through the Low Income Safety Seat Distribution and Education Program (LISSDEP). The child passenger safety program is funded through Highway Safety Funds, Traffic Revenues and the MCH Block grant. In FY13 the program distributed 14,306 safety seats and booster seats to indigent children. In addition, 49 children with mild medical needs were issued medically warranted devices through special accommodations that the program offers. This work was completed by 152 volunteer distribution sites housed primarily within local health departments. The Safety Seat Check Station Program provided routine child passenger safety education and installation assistance for 8,266 safety seats at 110 volunteer sites statewide. The program also inspected 2,203 safety seats and booster seats at 123 one-day safety seat check events throughout the state. The program distributed 167,203 pieces of child passenger safety resource materials.

F. Other Program Activities

The VDH Injury and Violence Prevention Program maintains Project RADAR which is a health care provider-focused effort that assists in effectively identifying, assessing, and managing patients experiencing intimate partner violence. Last year, the program conducted five workshops and a train-the-trainer session, resulting in 36 new trainers and more than 250 health care professionals trained in the RADAR method for intimate partner violence screening. Over 6,000 educational materials were disseminated to health care providers through these trainings.

Project Connect is part of a multi-state initiative which seeks to develop comprehensive models of public health prevention and intervention that can lead to improved health and safety for victims of sexual and domestic violence. Virginia's project focus lies in family planning and home visiting settings. The Injury and Violence Prevention Program in partnership with the Division of Child and Adolescent Health, the Virginia Home Visiting Consortium, and the Virginia Sexual and Domestic Violence Action Alliance, has developed assessment strategies and tools, training curricula, educational materials and policy/procedure guidance to better enable family planning clinic staff and home visitors to identify and provide support and referral to individuals and families impacted by domestic violence, sexual violence and reproductive coercion (DV/SV/RC).

In FY14, with funding from other sources, three full-day train-the-trainer events were held and attended by 16 home visitors, and 18 victim advocates. 8 half day workshops were held, attended by 85 home visitors, 8 family planning providers and 50 victim advocates. Additionally, more than 35,000 Project Connect safety cards and other provider/patient education materials were disseminated over the course of the year. Most significantly, through Project Connect, a number of policy changes have been implemented including new screening questions on reproductive coercion at residential domestic violence program intake, on-site health services in domestic/sexual violence programs, and Project Connect advised screening and safety planning protocol as home visitor benchmarks.

Although the three-year grant cycle for Project Connect pilot grantee states/sites ended in FY13, Futures Without Violence, with funding from the Office on Women's Health, contracted VDH as one of three sites in the country to provide technical assistance and mentorship to new grantees. Over the course of FY14, VDH's Sexual/Domestic Violence Healthcare Outreach Coordinator made site visits to Maryland and Oregon, providing health and advocacy staff with training and guidance to help them implement better training and policy around domestic/sexual violence and reproductive coercion. In addition to site visits, the Outreach Coordinator provided training at two national Project Connect grantee meetings and via webinars, conference calls, etc.

Virginia's Maternal Mortality Review Team (MMRT) continues to review all cases of death occurring to a pregnant or recently pregnant Virginia resident regardless of the cause of death or

outcome of the pregnancy. This multidisciplinary team meets six times per year to review de-identified case summaries and determine system factors contributing to the death. To date, the MMRT has identified several major risk factors for pregnancy-associated death and made recommendations to address them.

Many changes in policy and practice have occurred which relate specifically to recommendations made by the MMRT. Examples include improved screening for substance abuse, intimate partner violence and behavioral health among reproductive age women with the development of a universal screening tool; provision of resources and guidance documents for practitioners in addressing addiction and pain management and for medically assisted substance abuse treatment during pregnancy; and providing training to local medical examiners on the need for autopsies for pregnant or recently pregnant women. Reports from the team are often used by others to identify pertinent issues and establish an agenda for future work. For example, the Team's report on obesity as a contributor to maternal deaths spurred numerous public health education activities and at least one local initiative to combat pre-pregnancy obesity. On a regional level, a collaborative project with Florida's Pregnancy-Associated Maternal Mortality Review Team was undertaken and resulted in the publication of an article entitled "Pregnancy-Related Deaths Due to Pulmonary Embolism: Findings from Two State-Based Mortality Reviews." Nationally, the Team was invited to present their findings on domestic violence and maternal death at the National Perinatal Association's Maternal Mortality Meeting.

The Team examined the case review process and made some changes in order to improve timeliness of case review. After some discussion as to length of discussions and availability of participants, two hours were added to the existing meeting days. Some principles were developed on how to limit unnecessary discussion and better use the consensus process already in place. On a national level, representatives from Virginia's MMRT participated in the Centers for Disease Control and Prevention/Association of Maternal Child Health Programs Maternal Mortality Initiative which was a year-long project designed to strengthen current state-based reviews and provide guidance documents and resources for teams starting reviews.

Plans for the coming year include improving the Team's capacity for conducting culturally competent case reviews, examining data to identify major risk factors for pregnancy-associated death in Virginia, and preparing a formal report with recommendations for prevention and intervention. In addition, the team will continue to collaborate with national interest groups on the function and process of maternal mortality review and incorporate best practices into the existing project. The Team will examine all data associated with deaths due to drug overdose and develop a report.

In response to the VDH Thriving Infants Strategic Plan launched in 2013, several implementation teams have begun work in areas that are not directly related to the national and state performance measures but are critical to the state efforts to reduce infant mortality. In order to make progress implementing the IMSP, implementation teams comprised of volunteer partners have formed around strategies in the plan to develop detailed workplans and begin activities to address that particular strategy and its objective. VDH sponsors the Virginia Breastfeeding Advisory Committee of which a subcommittee has been formed to promote breastfeeding. The Breastfeeding Implementation Team will focus on increasing the number of Baby Friendly hospitals in the Commonwealth. One major activity will be to host a summit in 2014 for hospital leadership to encourage commitment to this goal.

The Implementation Team on Smoking Cessation during pregnancy is focusing on the promotion of the Virginia Quit Now, the telephonic smoking cessation program, to both health department and private providers of prenatal care.

One strategy in the Thriving Infants Strategic Plan is to increase birth interval since short birth interval has been associated with preterm birth and infant mortality. One of the Implementation Teams is focusing on increasing the use of long-acting reversible contraception in the immediate

postpartum period. This group led by the Dean of the School of Medicine at Virginia Commonwealth University and comprised of representatives from ACOG, Department of Medical Assistance Services and other state leaders are exploring the barriers and challenges interfering with this practice and will generate specific action steps to ameliorate those barriers.

There is interest in other teams regarding maternal mental health including the screening for psychosocial risk factors, establishing pregnant medical homes, safe sleep, obesity reduction and healthy nutrition, and shaken baby syndrome. Some of these are in their early stages of formation.

The State Child Fatality Review Team was established in the Code of Virginia by the Virginia General Assembly in 1994. The Team reviews the circumstances of child deaths and develops recommendations to prevent similar deaths and to improve the report and investigation of these fatalities. Membership on the State Child Fatality Review Team is set out in statute. The Virginia Sudden Infant Death Syndrome (SIDS) Alliance had merged with the SIDS Mid-Atlantic but since December 2013, that organization has also been disbanded. Therefore, neither of these organizations is represented on this Team. The Board of the Virginia Department of Social Services is requiring regional fatality review teams so staff for the State Team have provided numerous trainings and orientations during this recent reporting period in order to assist these regional teams to be established and begin deliberations. The Team met six times in 2013 and has reviewed all of the 2009 sudden unexplained infant deaths. Of the 119 cases reviewed, sleep environment was the major risk factor associated with these deaths. A completed report of the findings and recommendations were released in March 2014. These findings have already been useful to the State Health Commissioner's efforts to reduce the number of infant deaths. In January 2014, the Team began examining child deaths due to poisoning. A toxicologist from the Virginia Poison Center has been appointed as a special advisor to the Team.

G. Technical Assistance

The Deputy Director of the Office of Family Health Services, Lauri Kalanges, M.D., M.P.H., and the Children with Special Health Care Needs Program Director, Sidnee Dallas, M.Div., M.P.H., are participating in the AMCHP New Director Mentor Program (NDMP). This mentorship pairs VDH leadership with an experienced Title V director from another state to orient the new Title V Directors and senior direct reports. According to AMCHP, the purpose of the NDMP is to provide new Directors with information, tools and resources necessary to succeed and grow as Title V administrators. This program will provide a platform for technical assistance that VDH will utilize in the planning, administration, and evaluation of Title V activities as well as Office wide efforts to engage in strategic planning around the Title V priorities.

The Virginia Title V program continues to be interested in receiving training on the integration of the life course model into planning and programming. As part of the life course perspective, specific areas of interest include preconception care and quality improvement. Particular emphasis on how to apply the life course model and evaluate the effectiveness would be a requested component of the training. Virginia Title V program staff expressed an interest in training modalities that include face to face interaction with a trainer.

As the Affordable Care Act (ACA) is implemented, the opportunity to have trainings and discussions regarding the impact of the ACA on the delivery of Title V and population-based services would be beneficial. VDH plans on identifying and participating in planned webinars and trainings about the ACA and the effects of health reform on services provided by state health agencies. In addition, developments related to national and state health information exchange and electronic medical records would be helpful.

V. Budget Narrative

Budget and expenditure data from Forms 3, 4, and 5 are provided for the application year, interim year, and reporting year to assist the reviewer in analysis of the budget and expenditure narrative. For complete financial data, refer to all the financial data reported on Forms 2-5, especially when reviewing the federal allocation on Form 2 for the 30%/30%/10% breakdown for the budgets planned for primary and preventive care for children, children with special health care needs, and administrative costs.

Form 3, State MCH Funding Profile

	FY 2013		FY 2014		FY 2015	
	Budgeted	**Expended**	**Budgeted**	**Expended**	**Budgeted**	**Expended**
1. Federal Allocation *(Line1, Form 2)*	12369389		12369389			
2. Unobligated Balance *(Line2, Form 2)*	0		0			
3. State Funds *(Line3, Form 2)*	9470031		9277042			
4. Local MCH Funds *(Line4, Form 2)*	0		0			
5. Other Funds *(Line5, Form 2)*	0		977807			
6. Program Income *(Line6, Form 2)*	500000		500000			
7. Subtotal	22339420		23124238			
8. Other Federal Funds *(Line10, Form 2)*	156035618		145527761			
9. Total *(Line11, Form 2)*	178375038		168651999			

Form 4, Budget Details By Types of Individuals Served (I) and Sources of Other Federal Funds

	FY 2013		FY 2014		FY 2015	
I. Federal-State MCH Block Grant Partnership	**Budgeted**	**Expended**	**Budgeted**	**Expended**	**Budgeted**	**Expended**
a. Pregnant Women	3792803		3103273			
b. Infants < 1 year old	745700		1866126			
c. Children 1 to 22 years old	7538994		5556754			

d. Children with Special Healthcare Needs	9086923		8174418			
e. Others	0		3119460			
f. Administration	1175000		1304207			
g. SUBTOTAL	22339420		23124238			
II. Other Federal Funds (under the control of the person responsible for administration of the Title V program).						
a. SPRANS	0		0			
b. SSDI	65357		91045			
c. CISS	150000		300000			
d. Abstinence Education	828000		825444			
e. Healthy Start	1050000		787500			
f. EMSC	0		0			
g. WIC	134589737		123415788			
h. AIDS	0		0			
i. CDC	6574445		5261497			
j. Education	0		0			
k. Home Visiting	0		7864101			
k. Other						
DMAS	447500		447500			
Family Planning	4499174		3521815			
MCHB	7351405		1038843			
Pregnany Assistance			1494228			
SAMSHA	480000		480000			

Form 5, State Title V Program Budget and Expenditures by Types of Services (II)

	FY 2013		FY 2014		FY 2015	
	Budgeted	**Expended**	**Budgeted**	**Expended**	**Budgeted**	**Expended**
I. Direct Health Care Services	9443824		8549031			
II. Enabling Services	6473684		4782092			
III. Population-Based Services	518807		2545979			
IV. Infrastructure Building Services	5903105		7247136			
V. Federal-State Title V Block Grant Partnership Total	22339420		23124238			

A. Expenditures

The completion of this section regarding Title V expenditures is in progress and will be completed prior to the grant submision on July 15, 2014.

B. Budget

The completion of this section regarding the Title V budget is in progress and will be completed prior to the grant submision on July 15, 2014.

VI. Reporting Forms-General Information
Please refer to Forms 2-21, completed by the state as part of its online application.

VII. Performance and Outcome Measure Detail Sheets
For the National Performance Measures, detail sheets are provided as a part of the Guidance. States create one detail sheet for each state performance measure; to view these detail sheets please refer to Form 16 in the Forms section of the online application.

VIII. Glossary
A standard glossary is provided as a part of the Guidance; if the state has also provided a state-specific glossary, it will appear as an attachment to this section.

IX. Technical Note
Please refer to Section IX of the Guidance.

X. Appendices and State Supporting documents
A. Needs Assessment
Please refer to Section II attachments, if provided.

B. All Reporting Forms
Please refer to Forms 2-21 completed as part of the online application.

C. Organizational Charts and All Other State Supporting Documents
Please refer to Section III, C "Organizational Structure".

D. Annual Report Data
This requirement is fulfilled by the completion of the online narrative and forms; please refer to those sections.